Front desk talk: A study of interaction between receptionists and patients in general practice surgeries

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Abstract

Receptionists who work in general practice surgeries in Great Britain are part of a large, state-funded organisation, the National Health Service. Their duties include registering patients with practices, arranging appointments for them and checking them in for consultations, as well as administration of the ordering and collection of repeat prescriptions. In this study the talk-in-interaction through which these activity types are accomplished at three general practice surgeries in Scotland is analysed and the discursive construction of roles and identities by receptionists and patients in the three separate, but related, institutional contexts explored.

The discourse through which front desk activity types are accomplished at all three sites is found to consist of a maximum of four stages. These are present in varying combinations in different activity types but are always constructed through predictable combinations of moves, which, except in encounters in which problems are resolved or errors remedied, are realised through a limited range of speech acts and conversational routines. Different choices of act or routine encode differing levels and styles of face protection, which appear to be determined by factors such as the social environment of each practice, the preferred relational approach of individual participants and the perceived level of imposition which an activity type entails. In addition, participants are found to adopt varying stances towards personal agency. While some assume full responsibility for their actions, in others agency is either disguised, for example when receptionists attribute decisions to other practice sources, or downplayed, for example when patients present themselves as needy or inexpert.

Although there are variations both in the discourse at different practices and the positioning of individual receptionists and patients, both groups of participants are found to orient strongly to their institutional roles, only rarely drawing on the wider identity resources available to them. Receptionists seem intent on task completion, while patients are focused on attaining service goals, in both cases at the expense of interpersonal communication. As a result, relative to service encounters in other contexts, levels of remedial action are low and there is very little small talk. Thus, paradoxically, although general practice surgeries provide intimate personal care for patients, at their front desks relational matters do not appear to be a primary concern.

A narrow focus on transactional goals and a neglect of the relational function of discourse may give rise to negative perceptions among both receptionists and patients. It is therefore proposed that the findings from this study be used in receptionist training programmes to raise awareness of patterns of discourse behaviour at the front desk, with a view to improving both the professional experience of receptionists and the quality of service which patients receive.

Declaration

In accordance with regulation 2.5 of the postgraduate assessment regulations for research degrees, I hereby declare that I have composed this thesis myself, that the work it contains is my own and that it has not been submitted for any other degree or professional qualification.

Heather Mary Hewitt
Edinburgh, June 2006

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The extracts from the transcriptions (see Appendix 1) which are cited in the thesis are referenced as follows:

Sample reference:	(Practice B, Disc 4, Track 1, 02-04, F/41-60/lm/om)
Practice B:	the code-name of the practice
Disc 4:	the disc on which the recording is found
Track 1:	indicates which track the extract comes from. This only applies to Practice A, Discs 2 and 3, Practice B, Disc 2 and Practice C, Disc 3
02-04:	shows the location on the disc in seconds and appears in the left-hand margin in the transcripts
F:	sex of patient, e.g. F: female
41-60:	age band of patient
lm:	date of last attendance at practice, e.g. lm: last month
om:	frequency of attendance at practice, e.g. om: once a month

Each participant has a code name, which works as follows:

RA1:	the first (1) receptionist (R) in the data from Practice A (A)
PC47:	the forty-seventh (47) patient (P) in the data from Practice C (C)
IA:	independent adviser

All the names used in the extracts are pseudonyms.

(Full details of the coding systems and transcription conventions which were used can be found in Appendix 1, page 314.)

Chapter 1

Introduction

1.0 Introduction

This is a study of talk-in-interaction between receptionists and patients at the front desks of general practice surgeries. Unlike medical practitioners, whose service to patients is constituted from a combination of discursive, physical and technical resources, medical receptionists accomplish their work with patients exclusively through spoken and written verbal means. Here the focus is exclusively on spoken discourse. Using audio data recorded at three general practice surgeries (henceforth GP surgeries) in Scotland, I first explore the verbal structure of front desk encounters, describing recurrent transactional and relational patterns as well as variations in their enactment; second, examine the different roles and identities which are co-constructed by receptionists and patients as they pursue their discourse goals; and third, consider how a detailed knowledge of front desk discourse patterns might be used to inform receptionist training. In this introductory chapter, I explain how my interest in front desk talk developed; describe the institutional context of general practice reception work; and give a brief outline of the analytical frameworks which I draw on.

1.1 Background

An episode of talk between a receptionist and a patient at the front desk of a GP surgery is a form of service encounter, a genre which Merritt describes as:

> an instance of face-to-face interaction between a server who is 'officially posted' in some service area and a customer who is present in that service area, that interaction being oriented to the satisfaction of the customer's presumed desire for some service and the server's obligation to provide that service. (1976: 321)

Both the "transactional" and the "interactional" functions of service encounters, respectively expressing "content" and "social relations and personal attitudes"

(Brown and Yule 1983: 1), have been the subject of detailed critical attention (see §2.2). My own interest in service encounters was first stimulated by the work of McCarthy (2000), who looks at the co-occurrence of transactional and relational talk in client encounters with hairdressers and driving instructors, and Kuiper and Flindall (2000), who discuss the routine sequences of formulaic speech used at supermarket check-out points, focusing on the personalisation of these ritual interchanges.

In order to explore these features further, using a framework which was informed by Ventola's (1987) systemic functional mapping of generic structure potential, as well as by the two papers mentioned above, I investigated encounters between bus drivers and passengers on pay-as-you-enter urban bus services (Hewitt 2001a). I found that, while bus drivers and passengers collaborated in the pursuit of transactional goals, the driver's dual role as both provider of the service and gatekeeper or controller of passenger access, influenced the relational structure of the talk. More precisely, drivers appeared to have different speaking rights from passengers, a disparity which seemed to reflect a power asymmetry in the driver's favour.

The gatekeeping role of bus drivers is similar to that of receptionists in mainly stationary environments. As my next step I therefore made a contrastive study (Hewitt 2001b) of the discourse of receptionists in two other commercial contexts, a veterinary surgery and a small vehicle repair centre, which were matched both for size and content of work[1]. Although the encounters were longer than those in the doorways of buses and consequently far more complex, the generic structure of these encounters was broadly similar to those involving bus drivers and passengers and it could again be seen that there were restrictions on the speaking rights of clients. However, the power differential in the provider's favour was less salient than in driver-passenger encounters, except in the case of the garage owner, who frequently acted as his own receptionist.

Knowing that there was already a substantial body of work not only on service encounters but also on both gatekeeping and power relations in institutional

[1] Vets repair animals while garages repair cars.

discourse, I wished to explore this discourse type further in a context which would satisfy my preference for research which might eventually be of practical value. I became aware that the goal of easy access to medical services had become an important one for the National Health Service both throughout the UK (see Royal College of General Practitioners 2002) and specifically in Scotland, where it had been included in a policy statement on the future of health care (Scottish Executive 2000a) and been the subject of an independent study (Scottish Consumer Council 2001). Receptionists were singled out in both documents as vital to the process of facilitating access for patients. In addition, it had recently been proposed that primary health care be subject to greater professional scrutiny through the introduction of a practice accreditation scheme, which would ensure that all practices maintained certain standards in all aspects of their work, including the performance of receptionists (Scottish Executive 2001).

Despite the recognition of the importance of the general practice receptionist (henceforth GP receptionist) in the delivery of primary care services, it appeared that receptionist training was neglected. The one- or two-day courses on offer in the region where I proposed to conduct the study included introductions to customer care, telephone skills, health and safety, management of violence and deaf awareness, as well as the more substantial practice receptionist programme, which could lead to an Association of Medical Secretaries, Practice Managers, Administrators and Receptionists (AMSPAR) certificate or a Scottish vocational qualification (SVQ). However, GPs are independent contractors, who are able to make their own decisions about the use of their budgets, and, despite the efforts of AMSPAR, who have several accredited training centres in Scotland (AMSPAR 2004), there was limited uptake of these courses and many GP receptionists received no formal training (personal communication from the director of the regional general practice staff training scheme).

A review of the relevant literature revealed that the need to provide GP receptionists with better training was also seen as pressing because, like the claims processors described by Wenger (1998), many were doing work with serious implications for

clients without fully understanding the procedures. Bolanakis (2004), for instance, argues that "it is of paramount importance that the repeat prescribing process in each GP surgery is both safe and efficient. Receptionists and prescription clerks play a significant role in this process yet the training they receive is often unsatisfactory". In sum, although the medical training of both doctors and patients has developed over the last thirty years to include communication skills (see General Medical Council 1993; Cegala and Broz 2003), the training of receptionists has remained a low priority, confirming Cicourel's (1999a: 217) view that "the clinical process begins with the discourse practices of personnel not trained in healthcare delivery".

It also emerged that, despite the growing interest in health care communication, with the notable exception of the work of Cicourel (1999, 2000/1), who used linguistic analysis of appointment-making by receptionists in a paediatric clinic to further sociological understanding of the "structural and processual aspects of health care delivery" (1999: 183), there had been no specific studies of interaction involving medical receptionists. In the light of all these points, it seemed to me that here was a context in which my own initial findings about receptionist-client interaction might be of some value.

1.2 General practice reception work in Scotland

In common with other residents of the UK, most patients in Scotland receive medical treatment through The National Health Service (henceforth NHS). Although the use of private healthcare provision is on the increase (Research and Markets 2004), private provision remains low in the primary care sector and the NHS remains the largest public healthcare service in the world (The Mature Market 2005). Its main remit is the provision of universal medical care which is, to use the catchphrase of the organisation, "free at the point of delivery". The first point of contact with the NHS for the majority of patients is through the surgery of a general practitioner. In fact, over 90% of medical encounters in the NHS take place in primary care, which, Colin-Thomé (2004) claims, "is the shop window of the NHS. Nine out of ten

patients are seen in local family practices and some 300 million appointments are made every year."

Not only do GPs provide primary medical care but also, through the writing of prescriptions and hospital referral letters, authorise access to drug treatments and specialist secondary care for patients. They also legitimise entitlements to financial assistance from the state in the form of sickness pay and incapacity, disability and maternity benefits as well as contributing to applications for state housing; and helping to determine which patients should receive direct support from nurses or social workers. GPs therefore facilitate access to a whole range of welfare services (see van den Brink-Muinen et al 2003; Gonzales 2004) and furthermore, through their contract with NHS Boards, have a statutory obligation to fulfil this administrative function. Thus, although their central role is the provision of healthcare, GPs can also be seen as administrators who "function as gatekeepers of a social order" (Sarangi and Slembrouck 1996: 37).

A GP medical team is a community of practice (Lave and Wenger 1991, Wenger 1998) within a wider institutional network, which consists of all other personnel in the fields of health, and sometimes social[2], care. Within each GP community of practice are embedded various sub-communities. These include groups of nurses and specialists[3] on the clinical side and clerical workers on the administrative one. GP receptionists are members of this latter group although distinct within it because, in contrast with other administrative personnel, who only meet members of the public occasionally, they have regular direct contact with patients. A receptionist's face-to-face work with patients includes registering them as practice members, allocating appointments, checking them in when they arrive for appointments, handing out documents ratified by GPs and, in some practices, policing behaviour in waiting areas. Behind the-scenes, as well as ensuring that patient records are kept up-to-date and organising their use by medical staff, receptionists process and file the numerous documents which come in and out of practices. These include registration forms,

[2] Attempts are being made in Scotland to integrate social and medical services, following the agenda of the Joint Future Group's Report *Community Care: A Joint Future* (Scottish Executive 2000b).
[3] For example, physiotherapists, occupational therapists, chiropodists and psychiatrists.

requests for repeat prescriptions, test results, letters to hospital personnel and applications for certain benefits.

In effect then, GP receptionists have a dual role. In their public role they act as gatekeepers for GPs, who are themselves, as we have seen, often regarded as gatekeepers to the whole healthcare system. At the same time, out of the public eye, they play a part in the documentation side of the bureaucratic process. This combined content of their work makes them "street-level bureaucrats", as defined by Prottas (1979) and Lipsky (1980), bureaucrats, that is, who effect the transformation of private individuals into administrative cases. Thus receptionists, despite being service purveyors rather than service providers, play an important part in ensuring the efficient management of medical care. Their role is vital since they stand at the boundary, at the point where the private person becomes the institutional case, and are required to ensure smooth transition between the two. Indeed, in his study of access to social services, Hall (1974: 23) goes so far as to suggest that the reception process is crucial to the service and "…the degree of efficiency with which clients are enabled to use the services provided may be largely dependent upon the skill and resources of the intermediary".

1.3 Analytical framework

As already mentioned, my intention at the outset of this research was, firstly, to identify the linguistic norms and practices of front desk service encounters; secondly, to examine how receptionists and patients enact their respective social roles and identities; thirdly, to investigate the extent to which these linguistic norms and practices are implicated in the construction of and orientation to institutional power asymmetry; and fourthly to develop a means of using my findings to inform training programmes, in particular by raising awareness of ways in which the verbal performance of receptionists might be perceived as failing to facilitate access to medical treatment. On this basis, four research questions were formulated:

1. What are the typical patterns of staging and sequencing[4] in the speech routines used by receptionists and patients in their interaction?

2. What variations are there in the enactment of these patterns?

3. What do such variations reveal about the participants' construction and understanding of the interaction?

4. How can the findings be used to improve receptionist communication through training?

In order to answer these four questions it was necessary first to record and transcribe examples of naturally occurring interaction from the front desks of GP surgeries. This process is described in detail in Chapter 3.

A principle of organisation also had to be found for the ensuing analyis. Each of the four research questions demanded a slightly different analytical focus. For the first two steps, in which episodes of interaction were categorised and organised and different transactional stages identified, I drew both on genre theory, particularly as it has been applied to service encounters (see e.g. Ventola 1987; McCarthy 2000), and Levinson's (1988) idea of activity types while, for the next step, in which the sequences within stages were examined in greater detail, I used techniques derived from conversation analysis (henceforth CA) (see e.g. Merritt 1976, 1980) and the Birmingham school of discourse analysis (see Sinclair and Coulthard 1975, Stenström 1994).

My analysis of relational patterns is based on the ideas of Goffman: his notion of face (1955, 1969), which resurfaces in theories of linguistic politeness (e.g. Brown and Levinson 1987; Spencer-Oatey 2000; Watts 2003), and his ideas on footings and frames (1974, 1981), which have been used to develop theories relating to discourse

[4] The term 'staging' refers here to phases in the interaction such as opening and closing, and the term 'sequencing' to pairs or groups of moves, such as questions and answers, which occur within stages.

roles and participation formats (e.g. Erickson and Schultz 1982; Levinson 1988; Tannen 1993). The discussion of roles and identities is also informed by the CA concept of membership categorisation (Sacks 1992, Hester and Eglin 1997) and, specifically, by Zimmerman's (1998) proposal that speakers make relevant three forms of identity, "discourse", "situated" and "transportable", as they position themselves through talk.

Finally, for training models I looked to the work of Roberts and Sarangi (2002) and their collaborators in the field of health communication, Channell (2000) for her work with receptionists and Carter and McCarthy (1997, 2000) for the general principles involved in the use of naturally occurring discourse for pedagogical purposes. Underpinning the whole study, there are also the extensive literatures of health sociology and communication and institutional discourse, to which I will turn in the next chapter.

1.4 Outline of thesis

In this chapter I have

- introduced the theoretical framework on which the study is based;
- outlined the development of my interest in institutional talk, particularly service encounters;
- provided background information about GP reception work in the NHS in Scotland;
- indicated what I set out to achieve in this study, and how.

The remaining chapters are organised as follows. Chapter 2 contextualises the study in the relevant literature. Chapter 3 is an account of the research methodology and method. In Chapter 4 regularities and variations in the transactional structure of receptionist-patient encounters are described while in Chapter 5 the accompanying relational patterns are reviewed, with particular emphasis on remedial interchanges. In Chapter 6, there is analysis of the construction of discourse positions through

variations in person reference, speech style and topic and, in Chapter 7, detailed discussion of identity construction in three encounters in which problems are dealt with. Finally, in Chapter 8, the implications for receptionist training are considered in the context of a review of the study and a consideration of the social meanings which are constructed through front desk discourse.

Chapter 2

The institutional and discourse contexts of front desk talk

2.0 Introduction

How data are to be analysed is partly determined by the desired relationship to other studies while awareness of relevant, or related, studies both helps the researcher to avoid analytical traps and makes it possible for the findings to be used to inform and develop knowledge within existing models (see Antaki et al. 2002; Daly et al. 1992b). This study is situated within the broad institutional context of research into the delivery of health care but its main relationships are with studies of institutional discourse in general, and with those of service encounters, institutional gatekeeping, and doctor-patient communication in particular. Consequently, in this chapter I begin by reviewing studies of the institutional contexts of front desk work. I go on to examine the main frameworks adopted in studies of encounters involving institutional and lay participants. I then provide detailed reviews of the three forms of talk which converge in front desk discourse: service encounters, gatekeeping encounters and doctor-patient encounters. Finally, I outline the theoretical positions which have been adopted with regard to the use of naturally occurring data to inform training programmes for institutional personnel.

2.1 The healthcare context

The encounters between the GP receptionists and patients considered in this study take place in GP surgeries, which are part of the NHS. Both the structure and the ethos of the NHS as a whole naturally affect the behaviour of both receptionists and patients, as do prevailing social attitudes to health and illness. In addition, the front desks of surgeries have their own distinctive beliefs and practices. In this section I shall therefore first outline prominent theories of health care, suggesting how they manifest themselves in the NHS, before going on to summarise studies of the work of receptionists.

2.1.1 Health care

In a 1999 paper, Hydén and Mishler (1999:185) commented that "the health field has become a contested space where alternative conceptions of illness and treatment compete with the dominant tradition of Western scientific medicine". The dominant tradition is epitomised by Parsons' (1952) view that there is an unwritten contract between physician and patient: the physician's technical expertise entitles him[5] to the institutionally ratified role of healer while the patient has an accepted sick role, whose characteristics include exemption from normal social responsibility and the obligation to seek technically competent help in order to achieve the goal of recovery. While the most notable features of the medical role are objectivity, affective neutrality and technical competence, those of the sick role are helplessness, dependence, emotional involvement and technical incompetence.

Among the alternative conceptions of illness and treatment which have developed since Parsons made his analysis are a shift away from the notion of the patient as a dependent outsider, which is inherent in the concept of the sick role, towards an increase in lay involvement in medical decision-making and an acknowledgement of the value of the individual's subjective experience of illness (see Lawton 2003). This shift, which has been encouraged both by feminist critics of male medical dominance (e.g. Fisher and Todd 1983; West 1984) and the movement for patient involvement (e.g. Balint 1957), finds a more extreme expression in the idea that the human body has become an aspect of the commodified self (see e.g. Frank 1991). In this interpretation, the sick role has been superseded by the health role, in which, assisted by the increased availability of health-related information through the worldwide web (see e.g. Annandale and Hunt 1998; Hardey 1999), the individual assumes responsibility for health maintenance through appropriate lifestyle choices, thereby further reducing the centrality of the physician.

The physician also takes a secondary role in Foucault's (1973) theory of health care provision. For Foucault, medicine is one of many institutional instruments of social

[5] When referring to physicians Parsons used the generic masculine pronoun.

control, and the "clinical gaze" part of a "panoptic system of surveillance", which was first developed in the late eighteenth century, (see also Freidson 1970; Zola 1972; Illich 1976, Waitzkin 1985; Navarro 1986). This view is supported both by the work of observers such as Frank (ibid.), who draws attention to the institutionalisation of the medical profession and the increasing influence of corporate managers on medical agendas, for example, through media campaigns, and by Williams and Calnan (1996: 13), who suggest that physicians in the UK are being "deskilled, losing their economic independence, and being required to work in bureaucratically organised institutions under a new cadre of managers".

In the NHS, the trend towards increased lay involvement was reflected by the introduction in 1991 of The Patient's Charter (McNab 1999), a document which was designed to redress the clinical balance in favour of patients and involve them in medical decision making at all levels. Although the Charter was revoked in 2000, other measures have since been put in its place, including NHS Quality Improvement Scotland (2003), which has a public involvement unit and numbers lay reviewers among its monitors of service quality. The trend towards centralised corporate management has also been reflected in changes to the administrative structure of the NHS since its inception in 1948, although the changes have had a greater impact on providers of secondary healthcare than on GPs, who, because they are independent contractors, have been affected only indirectly through the modification of regional management structures and the GP contract (The National Health Service 2004).

In practice then, as Hydén and Mishler suggest, a mixture of attitudes and approaches is likely to be found. While the influence of central decision-making cannot be denied (e.g. Department of Health 2004; National Institute for Health and Clinical Excellence 2006), there is still also a place for what Williams and Calnan (1996: 7) describe as the "preferred self-image [of the medical world] as a scientific, morally neutral and value-free institution, predicated upon an altruistic concern for both patient and community welfare". Similarly, although in some situations, patients may be active participants both in health care and health maintenance, in others, as Shilling (2002: 635) reminds us, in an endorsement of Bourdieu's (1984) argument

that symbolic resources are unevenly distributed in society, "the traditional Parsonian approach towards the sick role may continue to retain some value for analysing the medical relationships of those who are unable to access, or are alienated from the proliferation of health-related information" (see also Scambler and Britten 2001). Furthermore, although a more contractual relationship between practitioner and patient is thought to be emerging in place of trust in professionalism (Bury 1997), GPs often have a monopoly, particularly in rural areas (L. McCloughan, personal communication), with the result that patients cannot exercise choice over which practice they join.

Changes in attitude and outlook have an impact on communicative styles. For example, in the late 1970s Strong suggested that, by putting serious time constraints on doctors and removing the incentive of competition, the nationalisation and bureaucratic organisation of medical practice had led to the development of a communicative style, the bureaucratic format, which was "impersonal, highly-controlled and relatively uninformative" (1979: 208), but also pointed out that "it pays doctors to be polite to the great mass of patients" because "the financial position, prestige and degree of self-control of the professionals as a whole are under direct political management" (1979: 215). In contrast, Walshe (2005), writing at the time of the 2005 General Election in the United Kingdom, had moved to a more patient-centred understanding of an appropriate medical communication style, claiming that "[t]he principle that patients should be treated as enfranchised consumers rather than as passive recipients of services is universally accepted".

Although both Strong and Walshe were thinking primarily of the communicative approaches of physicians, it is anticipated that divergent views of health care provision will also be reflected in the discourse positioning of receptionists and patients and may influence their "construction and understanding of the interaction" (research question 3), as will the primary care experiences of the two groups and their attitudes to one another. These are considered in §2.1.2.

2.1.2 GP receptionists

The findings from the relatively small number of studies of GP receptionists and their work, either in the NHS or elsewhere, can be grouped under four headings.

1. *GP receptionists are often motivated by a wish to help people.*

Both Copeman and van Zwanenberg (1988) and Eisner and Britten (1999) were interested in the attitudes and experiences of receptionists. Copeman and van Zwanenberg (1988) interviewed 70 receptionists from 20 practices in the Newcastle upon Tyne area of England. Respondents were asked what they considered to be their most important function and "[w]ithout exception their responses concerned the patients and the service that patients need" (1988: 15). The same point is made again, more explicitly, by Eisner and Britten (1999) in their survey of receptionists' thoughts and feelings about their work: "… receptionists gain satisfaction from helping patients. They value long term involvement, and are upset by patients' distress or misfortune" (1999: 105).

2. *GP receptionists have low status and little training.*

The low status of GP receptionists is among the points raised in several papers (Bain and Durno 1982; Hughes 1989; Scottish Consumer Council 2001). Gosling (2002) found an economic reflection of low status in the discovery that receptionists who were promoted to the post of practice manager from within a practice earned much less than those who were recruited to the job from outside. On training, Copeman and van Zwanenberg found that only 13% of receptionists interviewed had received any formal training while Eisner and Britten established that the receptionists in their study were both inadequately trained and excluded from practice decision-making processes. This was a source of difficulty for them, exacerbating the already high levels of stress which they experienced. There are a number of papers in which proposals are made for remedying this situation through further training. They include studies by Essex and Bate (1991), who demonstrate that the competence of

receptionists could be extended to include audit of the achievement of practice goals in their job descriptions, Patterson et al (2000) and Coward (2003), who describe training schemes which would allow receptionists to take on additional responsibility for patient assessment.

3. *GP receptionists have a gatekeeping role which gives them a considerable amount of responsibility*.

One of the reasons for the high stress levels among receptionists may be the disparity between their low status and the high level of responsibility vested in them, particularly through their control of the allocation of appointments. The gatekeeping role of receptionists was thoroughly investigated by Arber and Sawyer (1985) in a paper whose title, 'The role of receptionists in general practice. A "dragon behind the desk"?', echoes the stereotypical view of NHS GP receptionists. They find that patients are more likely to "experience the receptionist as a gatekeeper" (1985: 913) in the following situations: when they interfere in medical affairs "which are not seen as their legitimate province" (1985: 918); when formalised rules, which lead to inflexibility, are introduced to manage a mismatch between patient needs and the number of appointments available; and when patients, particularly young adults and the mothers of young children, are 'typified' (see Schutz 1962) [6] as over-demanding.

Gatekeeping by receptionists is also the focus of a number of subsequent studies. Hallam (1993), who used a postal survey to canvas the opinions of patients in four practices on access to doctors by telephone, found that receptionists were regarded as obstructive. Gallagher et al. (2001) demonstrated how receptionists control access to appointments; Hughes and McCann (2003) found that community pharmacists also have difficulty in accessing GPs because of gatekeeping by receptionists; and Offredy (2002), as well as confirming all three of the main points made by Arber and Sawyer, pointed out that over-zealous gatekeeping can also lead to infringement of the patient's right to privacy. Two other studies include specific examples of this:

[6] For a summary of the theory of 'typification' see McKinney (1969) and, for a demonstration of how certain groups of primary care patients are negatively typified, see Husain-Gambles et al. (2004) (see also Hughes (1989), Griffiths (2001) and Murcott (1981).

Petchey et al. (2001) reveal how receptionists often fail to maintain confidentiality for patients who are HIV positive and Jacobson at al. (2001) show how teenagers in Wales experience a lack of respect for confidentiality when trying to obtain appointments.

4. *GP receptionists are often judged negatively by patients and are consequently on the receiving end of negative behaviour.*

The military term, 'frontline', is often used to refer to the situation of receptionists, as in the comments of Dr Ian Millington in a BBC news interview:

> I think the problem is that receptionists are there on the frontline. One of the difficulties with being on the frontline is that you are the first point of call if services behind you aren't able to deliver what patients expect and what they have been promised by politicians. In that situation, receptionists may be seen as obstructionist or difficult. They may come across as unresponsive and miserable… I am amazed at how often patients are rude to reception staff.
>
> (BBC News Online. Sunday, 13 July, 2003)

Being on the frontline can also mean being in the firing-line. The anecdotal evidence of increasing rudeness, and violent or threatening behaviour, towards receptionists is confirmed by five studies, all designed to examine aspects of the pressure on primary care staff. Heuston et al. (2001) outline the problems faced by receptionists when dealing with substance-abusing patients and suggest that extra training may be required to help them with this. Naish et al. (2002) discover from focus group discussions with two primary care teams from the London area that receptionists are the group most likely to face aggression from patients yet, in this case, on account of their exclusion from team meetings, are the ones least equipped to cope with it. Dixon et al. (2004) find that over two thirds of the receptionists who answered their postal questionnaire had experienced some form of verbal abuse over the previous twelve months and that there was a significant association between levels of abuse and levels of deprivation in practices. Threatening or abusive behaviour was the most common reason given to Munro et al. (2004) by GPs for removing patients from their lists, with almost half of instances involving verbal abuse towards receptionists.

The picture which emerges from the studies described above is of a group of workers who, though well-meaning, often find themselves interacting with clients who have generally negative attitudes towards them in situations which they lack either the authority or the training to deal with. These findings were also supported by interviews with, and observations of, the receptionists in this study, as well as by informal discussion with many health service users.

2.1.3 Summary

In this section it has been shown that front desk interaction in the first decade of the twenty-first century takes place in an institution in which a range of differing attitudes and understandings of health and illness are represented. Patients may experience the sick role as a form of dependency, accepting the authority and wisdom of the physician, but they may also be more active participants in both health care and health maintenance. Receptionists work in an environment which has witnessed an erosion of the power of the clinician as both governmental and corporate involvement have increased while, in their own role, they have high levels of responsibility but low levels of status and training, a combination which appears to result in frequently negative assessment of their performance.

2.2 Institutional discourse

Research on institutional discourse[7], or "institutional interaction" as Drew and Heritage (1992b: 3) term it, includes analysis both of communication practices within institutions (e.g. Holmes and Stubbe 2003; Koester 2004) and of talk at the interface of institutional and lay worlds. This study is a contribution to research in the latter category. In this section therefore I focus on approaches which have been used in studies of institutional-lay interaction, drawing attention to the main areas of interest for receptionist-patient discourse. I begin by considering the models which have been developed to analyse recurrent discourse patterns (§2.2.1). I then discuss

[7] I use this term rather than 'talk in institutions' since institutional discourse may take place off-site (see Heritage and Sefi 1992) while on-site talk in institutions does not always have an institutional content (see Holmes and Stubbe 2003).

the analytical frameworks which have been used in discussions of the discourse roles and identities of participants in institutional-lay encounters (§2.2.2). Finally, I examine representations of the issue of power, as manifested both at the macro level, through various discourse mechanisms (§2.2.3) and, at the micro level, through linguistic politeness (§2.2.4).

2.2.1 Discourse patterns

Like other interlocutors at the interface of institutional and lay worlds, receptionists and patients take part in many instances of the same type of interaction and "tend to develop standard practices to manage the tasks of their routine encounters" (Psathas 1995: 110). As a result, discourse patterns develop which are characterised by a "task-related standard shape" (Drew and Heritage 1992b: 43), with a predictable ordering of phases and recurrent patterns in the sequencing and shaping of turns. Participants in discourse orient to an awareness of these templates. These have been characterised by phenomenologists, such as Schutz (1962) and Garfinkel (1967) and their followers, as common sense knowledge and practical reasoning whereas they are thought by cognitivists to be retained in prototypical mental frames (Minsky 1977; Fillmore 1982), scripts (Schank and Abelson 1977) or schemata (Rumelhart 1980; Chafe 1994). While inexperienced speakers in any context are less likely to have developed these knowledge formats, and atypical activities are less likely to be schematised than frequently repeated ones, interactants invariably carry some form of expectation into encounters.

Several different approaches have been taken to the analysis of these discourse patterns. Conversation analysts (see Boden and Zimmerman 1991; Button and Lee 1987; Drew and Heritage 1992; Maxwell Atkinson and Heritage 1984; Psathas 1979) are most interested in the detailed turn by turn construction of talk, believing with Heritage (1984a: 290) that "it is within these local sequences of talk, and only these, that these institutions are only and accountably talked into being" (see also Gafaranga and Britten 2005). One of the main successes of CA has been the demonstration of how conversational actors in a variety of institutional settings orient

to the activities in which they are engaged and construct the discourse according to these orientations. Wilson summarises the process as follows:

> … participants simultaneously construct their interaction as a meaningful, accountable occurrence and reproduce its social-structural context as something that is, for them, an external and constraining social fact. (1991: 40)

It is this reproduction in discourse of 'social-structural context' which leads to the development of the speech genre, which is described by Fairclough (1992: 126) as "a relatively stable set of conventions that is associated with, and partly enacts, a socially ratified type of activity".

Genre analysts, who work from within a variety of frameworks, aim to identify the conventions which combine to create a genre (see e.g. Bhatia 1993, 2004; Biber 1988; Christie 2005; Christie and Martin 1997; Martin 1992; Miller 1984). These are likely to include a series of obligatory stages which, in turn, are constructed from predictable sequences of moves and also include conventional roles for participants (see §2.2.2). Although not working specifically as genre analysts, Sinclair and Coulthard (1975) were among the first to study the typical stages and sequences of turns in institutional interaction. They created a comprehensive taxonomy of classroom interaction, accounting for both macro and micro levels of discourse organisation in their rank scale model (see also Halliday 1961), which consists at its highest level of 'lessons' and continues through 'transactions' and 'exchanges' to the micro-organisation of discourse in individual 'moves' and speech 'acts' (see also Stenström 1994). However, according to Ventola (1989: 133), who was writing from a systemic functional perspective, the rank scale model privileged the canonical sequence of discourse elements over global text structure and failed to include "optional elements and various rules of how to sequence the elements". For Ventola and other systemic analysts (e.g. Hasan 1978, 1985), genre could only be accounted for by analysing the relationship between the field, tenor and mode of the discourse, respectively its ideational, interpersonal and textual features, which together form the register of a text.

In the work by Hasan and Ventola which is cited above the emphasis was on the transactional function (Brown and Yule 1983, see §1.1) and the stages of talk required for task accomplishment but, as McCarthy (2000: 84) points out, "genre models based predominantly on transactional achievements […] cannot account for participants' commitment to relational talk even when such talk may appear to be unmotivated" and genres are also distinguished by relational conventions. While the task-focused line of enquiry continues (e.g Taboada 2004), there has been a gradual shift to interest in the relational features of both written genres (e.g. Hyland 1998; Bhatia 2004) and spoken ones (Eggins and Slade 1997; Coupland 2000), as well as demonstrations that transactional and relational features are interdependent (e.g. Gavruseva 1995; Koester 2000, 2004; Merrison 2002).

In the systemic functional model, genres are seen as having a 'generic structure potential' (Hasan 1978), a set of features, some obligatory and others optional, through which they may be enacted. Genres in which similar activities occur are likely to have more features in common than those in which activities are quite different, since the structure of a genre is determined partly by its function. The relationship between form and function in a speech genre is set out by Bhatia, who sees a genre as:

> a recognisable communicative event characterised by a set of communicative purposes identified and understood by the […] community in which it regularly occurs. Most often it is highly structured and conventionalised with constraints on allowable contributions […].These constraints are often exploited by the expert members of the discourse community to achieve private intentions within the framework of socially recognised purpose(s). (1993:13)

Bhatia's definition is very similar to Levinson's (1992: 69) idea of the "activity type", namely, "a fuzzy category whose focal members are goal-defined, socially constituted, bounded events with constraints on participants, settings and […] allowable contributions". The relationship between the two terms is made explicit by Lemke (1998), who describes a speech genre as a highly-specific activity type accomplished mainly, although not exclusively, by verbal means.

Features such as the socially constituted structure, the definition by goals, and the existence of various types of constraint are common to both definitions. "Goal orientations" and "special and particular constraints" are also found by Drew and Heritage (1992b: 22) to be characteristic of institutional interaction. Drew and Heritage show that the constraints operating in institutional talk mark a contrast with the situation prevailing in casual conversation, which CA has taken as its default discourse, taking the form, for example, of the pre-allocation of turn-taking rights and limitations on the right to participate. They also suggest that these are extremely rigid in audience-viewed, legally-controlled interaction such as courtroom procedures (Maxwell Atkinson and Drew 1979) and news interviews (Heritage and Greatbatch 1991), less so in negotiable, behind doors, encounters such as those in healthcare contexts (Heritage and Sefi 1992).

Drew and Heritage also make explicit another point raised by both Bhatia and Levinson: that talk of this type generates its own inferential frameworks. The types of interpretation and inference to which institutional-lay encounters may give rise are exemplified by Heritage and Sefi's (1992) demonstration that straightforward advice-giving from a health visitor to a new mother may be taken as censure because of context-generated expectations. This contextual sensitivity has been the central theme of Gumperz' (1982a/b) work on the communication difficulties which participants from different cultural backgrounds face in encounters in institutional settings. He has shown that any feature of linguistic behaviour, from a prosodic change to a switch in code, can work as a contextualisation cue "by which speakers signal and listeners interpret what the activity is, how semantic content is to be understood and how each sentence relates to what precedes or follows" (1982: 131). He suggests that these cues are only perceptible to participants with "long-term exposure to similar communicative experience in institutionalised networks of relationships" (Gumperz 1997: 15) and that participants without such exposure are liable either to miss cues and inferences or have their own signals ignored or misinterpreted, leading to misunderstanding and, in extreme cases, the breakdown of communication.

Although they have many predictable features, speech genres are not fixed. Hanks (1990: 12) sees them as "action-centred processes of understanding", which give rise to regularities rather than rules, while ten Have (1989: 115) notes that "although participants use a similar cultural repertoire to structure their situations together, the actual interactional constitution of the occasion is locally negotiated". In fact, as Bakhtin (1986: 60, cited in Martin, 1992: 503) recognised, genres are created and shaped by individuals:

> The wealth and diversity of speech genres are boundless because the various possibilities of human activity are inexhaustible, and because each sphere of activity contains an entire repertory of speech genres that differentiate and grow as the particular sphere develops …

Heritage (1984a: 242), with his observation that talk is both "context-shaped" and "context-renewing", expresses a similar idea as do Auer and di Luzio (1992: 24) with their idea that context is both "brought along" and "brought about". Genres are thus constantly evolving with the possibility that old genres can change and new ones develop at any time, particularly, Drew and Heritage (1992b: 27) suggest, "[i]n a variety of less formal forms of institutional interaction – commonly occurring in medical, psychiatric, social-service, business, and related environments".

Finally, Linell (1998) sees the evolution and ongoing restructuring of institutional talk as re-contextualisation based on intra-textual, inter-textual and inter-discursive processes. Individual discourse types, described by Sarangi (2000: 1) as "specific manifestations of language form in their interactional contexts" come to be associated with specific activity types but, as Sarangi (2000: 14) shows, when discourse types migrate to new discourse environments, or atypical discourse types are "appropriated and introduced", an interactional hybridity develops, in which it becomes difficult to determine exactly which type of encounter is taking place. This is the case in the genetic counselling interviews studied by Sarangi, in which clinical and therapeutic discourses are intertwined, and in the bureaucratic discourse observed by Sarangi and Slembrouk (1996), which is overlaid by the discourses of advertising and 'lifeworld' talk (see Habermas 1984). It has also been observed that, when discourse types co-occur, interactional problems may arise. The point was

convincingly made by Jefferson and Lee (1992), in their detailed account of the convergence of service encounters with troubles-tellings, and raised again by both Whalen, Zimmerman and Whalen (1988) and Tracy (1997), in studies of clashes between service and institutional formats in calls to emergency services.

In all the cases described in the preceding paragraph the problem can be said to have arisen because interactants used divergent interpretive frames and, therefore, had different interpretations of their roles. As in other institutional-lay encounters, the roles and identities of receptionists and patients are partially pre-determined by their respective duties and goals but they may also find themselves in situations where a choice is possible, for instance between institutional and lay roles or between medical and lifeworld identities, for, as Bakhtin (op. cit.) infers, where there are human actors there is always the potential for development and flexibility. The models which have been used to analyse the roles and identity positions open to participants in discourse are discussed in §2.2.2.

2.2.2 Roles and identities

Following Goffman (1955), Sarangi and Slembrouk (1996: 80) observe that subjects are always speaking from within one or other role and "the essentialist idea of a unified social subject - a role-less true self- is lost". Goffman (1986) has made an influential contribution to the understanding of the roles and positions which are taken in talk. Schiffrin's (1990: 241-242) summary of his thinking covers three concepts: participation frameworks, footings and frames. The term *participation framework* captures the idea of the set of roles open to speakers and hearers, "a set of positions which individuals within perceptual range of an utterance may take in relation to what is said". Roles are developed as speakers assume *footings*, according to Schiffrin (op. cit.) "the alignments we take up to ourselves and the others present as expressed in the way we manage the production or reception of an utterance", and understood by Goffman himself (1981: 156) as "the capacity of the dexterous speaker to jump back and forth keeping different circles in play". In doing this, speakers recreate *frames*, "the organizational and interactional principles by which

situations are defined and sustained as experiences". Tannen and Wallat (1987: 206) describe these frames as *discourse* "structures of expectation" or interactive "frames of interpretation", (as distinct from *cognitive* "knowledge structures", such as scripts and schemata).

Goffman (1986: 517-523) identified four speaker footings: animator, who produces the utterance, author, who determines what will be in it, principal (or originator), who is responsible for it, and figure (or character), the persona enacted in it. Levinson (1988: 203), who elaborated on Goffman's work to create a more comprehensive taxonomy of speaker positions, suggests that roles are extremely complex and hard to attribute while Irvine (1996: 157) invokes Bakhtin's (1981) theory of heteroglossia when pointing out that "there is no necessary limit to the participation frames that can be imposed on the pragmatic present, fragmenting its participant roles and recombining them, in a complex calculus of mapping roles onto persons present and absent". As Hanks (1990: 78-79) however points out, different genres create different frame spaces, "a set of potential footings available to an interactant but not currently realised", and, for some speakers, the right to occupancy of certain frame spaces is restricted.

Aspects of Goffman's conceptual framework have been suggestively used in studies of institutional talk. Both Erickson and Schultz (1982) and Coupland and Coupland (2000) point out that there are both entitlements and responsibilities associated with relational frames, so that failure to align to a frame or failure to sustain the appropriate footing will be noticeable and negotiation will take place. Koester (2000: 197) claims that speakers use "frames or metastatements to signal their transactional as well as relational discourse goals: in other words goals in both getting things done and getting along". Heydon (2004) shows how footings are exploited during police interviews of suspects and Scollon and Scollon (2004) how their use differs in academic, journalistic and advertising discourses.

An additional feature of Goffman's (1986: 43-46) system is the 'key' which indicates a change of footing. Hanks (ibid.) draws attention particularly to the keying effect of

reporting forms (mentioned discourse, direct discourse and quoted discourse), lexical markers (real v hypothetical), verbs and particles, direct quotation, prosody, demonstratives and other deictic forms, also referred to as shifters. Tannen and Wallat (ibid.) make the more general observation that changes of frame and footing are keyed through changes of register, demonstrating their point in a discussion of a consultation in a paediatric clinic, where they find three observable registers, casual conversation, motherese and reporting, which are associated respectively with social encounter, consultation and examination frames. In an echo of Gumperz' work on contextualisation cues, Tannen and Wallat also show that, above all in institutional environments in which specialists and lay persons interact, interactive frames can clash, since linguistic cues do not always work in the same way for every participant. Their example is the word 'wheezing', which triggers a common sense interpretation in a mother (breathing sound) and a clinical one in a doctor (interruption in air passage).

Conversation analysts have also taken an interest in discourse roles and identities. For them different roles are constructed through emergent participant identities, which are made salient on the basis of the fact that, as Firth (1995: 27) states, "people are contingently sensitive to who they relevantly are, where they are, what they are attempting to do, and what is expected of them". As mentioned in §1.3, Zimmerman (1998), proposes three forms of identity: discourse identities (such as speaker/hearer, questioner/answerer), which are a feature of the immediate organisation of talk; situated identities (such as nurse/patient), which relate to the activity engaged in; and latent transportable identities (such as male/female), the physical or cultural attributes which move with individuals across situations and on which they are able to draw. He suggests furthermore that, in their identity work, speakers articulate and align the proximal and distal contexts of discourse, the first being the "turn-by-turn orientation to developing sequences of action at the interactional level" and the second the "oriented-to 'extra-situational' agendas and concerns accomplished *through* such endogenously developing sequences of interaction" (1998: 88). Identities in this view are the facets of an individual's behavioural range, referred to by Bourdieu (1977a) as the 'habitus', which are drawn

on during the enactment of a role. As Moerman (1988) comments, such identities are not things but processes, which only exist in so far as participants make them "procedurally consequential" (Schegloff 1992: 112-116) by orienting to them in their discourse.

Conversation analysts often uses the notion of membership categorisation (see Sacks 1992) to show how participants index identity in discourse. Rather than using pre-selected categories and attempting to demonstrate how they are realised in talk, analysts using this approach look at the terms in which speakers refer either to themselves or others in order to identify category groups which are relevant to them on the occasion of talk. Studies in membership categorisation (e.g. Hester and Eglin 1997) demonstrate how speakers use a variety of discourse practices to foreground aspects of their identities and so position both themselves and their interlocutors, in a discursive practice "whereby selves are located in conversations as observably and intersubjectively coherent participants in jointly produced story lines" (Davies and Harré 1990: 48). Positions are not fixed but subject to constant negotiation and renegotiation through lexical choice, narrative, evaluative stance and so forth. For example, the shifts between 'I' and 'we' as a medium of self-reference (Silverman 1987; Whalen, Zimmerman and Whalen 1988) and the alternation between lay and specialist vocabularies (Waitzkin 1985) are two linguistic features which also provide evidence of how participants in health-related encounters negotiate institutional identities.

In both Goffmanian and CA approaches it is shown that a multiplicity of positions is open to speakers and listeners. In the institutional context, participants can draw both on their lay identities and their officially sanctioned roles: McElhinny (1995), for example, shows how female police officers attending scenes of domestic violence switch at the boundary stage of encounters from their official identities, marked by long silences, the absence of backchannel comments and missing responses in adjacency pairs, to their gender ones, marked by a more affiliative style. The role thus allows for the expression of both these identity types. It is also open to lay participants to 'appropriate' an institutional identity by using the language

conventionally associated with it (see e.g. Gee 2001). In addition, as Roberts and Sarangi (1999: 38) point out, both groups can have particular identities 'ascribed' to them. This is the case in an episode described by Hall, Sarangi and Slembrouk (1997), in which, by highlighting negative characteristics, social workers construct a 'deficit client', who lacks the necessary competence to act independently. This example is characteristic in that it is the institutional member who performs the identity ascription and provides support for Agar's (1985: 43) belief that there is a diagnostic stage "through which the institutional representative fits the client frame to the institutional frame".

In their extended study of the language of bureaucracy, Sarangi and Slembrouck (1996: 19) find that institutional representatives have a strong tendency to impose routine procedures without attending to the client, seeing this as part of their "rationally and efficiently managing the needs and wants emerging from the private domain". In their view, while both bureaucrat and client have pre-inscribed roles, that of the client is more limited on a number of counts. First, stories told by clients will be interpreted by bureaucrats in direct relation to the institutional agenda; second, non-relevant client moves are liable to be ignored as opt-outs from institutional routine and therefore suspicious; third, clients are obliged to comply with all routine stages before reaching their goals; fourth, the bureaucrat is assumed to be cooperative and trustworthy but the client has to prove credentials; fifth, clients are expected to answer questions but may not have their own questions answered; sixth, bureaucrats can withhold information but, if they wish to achieve their goals, clients can not. In short, there is a power differential between institutional representatives and clients, which results from their differing levels of knowledge and responsibility and leads both to an unequal distribution of speaking rights and limitation on the client's capacity for conversational manoeuvre.

In the present study receptionists are in the role of bureaucrats (see §1.2) and patients in that of clients. However, as shown in §2.1.2, the status of receptionists within the organisation which they represent is low and their remit is to serve patients by facilitating their access to the free health care to which they are entitled. There is thus

potential in the front desk situation not only for foregrounding of different aspects of participant identities but, at the same time, for local negotiation of authority and power. Studies of the workings of power and the development of interactional asymmetries in discourse are therefore discussed in §2.2.3.

2.2.3 Power

Kaspar (2000: 318) suggests that the relationship between communicative action and social power "is […] particularly evident in institutional discourse" while Candlin and Hyland (1999: 10) affirm that the discourses of the professions above all others "regulate access to the roles, statuses and authority structures they realise in those contexts and sites". Thornborrow (2002: 4), whose ideas are similar to those set out by Sarangi and Slembrouck (ibid.), takes the view that these structures of authority and power are realised through four inter-related components:

1. differentiated, pre-inscribed participant roles and identities;
2. structurally asymmetrical distribution of turn types;
3. asymmetrical relationship between participants in terms of speaker rights and obligations;
4. the discursive resources and identities available to participants to accomplish specific actions are either weakened or strengthened in relation to their current institutional identities.

Linell and Luckmann (1991), in addition, find that asymmetry is constructed through quantitative (the amount of discourse produced), semantic (topics and lexis used) and strategic elements (importance of interventions made). They make a distinction between the asymmetry which is an intrinsic feature of discourse, and therefore one of the main motivations for communication, and inequivalences of knowledge, status and role, which lead to "restriction of an interactant's action environment" (Diamond 1996: 39-40). On the same lines, Ng and Bradac differentiate power *to* and power *over:*

> In the positive sense "power to" is the realisation of personal or collective goals. In the negative sense, it is hindering of other individuals' achievement of goals for the sake of hindering. "Power over", on the other hand, is the relational facet of power. One person has power over another person when the two stand in a relationship of dominance and submission (1993: 3)

Locher (2004) suggests that 'power *to*' is temporary, and associated with particular roles, whereas 'power *over*' is entrenched and hierarchical. Despite the fact that, in institutional events such as legal and police actions (see Harris 2001; Heydon 2004), asymmetry is often reinforced by sets of rules and regulations, both varieties of power are nevertheless open to modification, since power relations are complex and negotiated, even in highly routinised environments (see e.g. Gavruseva 1995; Maynard 1991a; Mills 2002). It should also be remembered, as Drew (1991) and Hak (2004) both show, that power asymmetries are not always apparent, and can therefore be invisible to the analyst as well as to the participant.

The aim of critical discourse analysis (henceforth CDA) is to reveal both these hidden effects and the more obvious influence of macro-structures of power on language production. This is, according to van Dijk (1998: 370) the most demanding of discourse analytical approaches since "it requires true multi-disciplinarity, and an account of intricate relationships between text, talk, social cognition, power, society and culture". Fairclough, the dominant figure in CDA, bases his work on the ideas of several social theorists who have had a wide influence in discourse studies. These include Foucault (1980: 142) for whom power is "a complex and continuously evolving web of social and discursive relations", which run through the whole of society and are reproduced in and through institutions, but can nevertheless be contested in the discursive practice of individuals since there are "no relations of power without resistances"; Bourdieu (1977a, 1991) for whom power is vested in the cultural resources, including language, on which people are able to draw; and Habermas (1984), who holds that different cultural tools are invested with different levels of authority. For Bourdieu, the legitimate language is prioritised and some speakers are more favourably endowed with symbolic resources than others, while Habermas sees the goal-oriented 'strategic discourse' which he associates with

cognitive-instrumental rationality as more authoritative than the 'communicative discourse' of the 'lifeworld' and everyday understanding.

Fairclough (1989, 1993, 1995a/b, 2000), has focused attention on public discourse, including the media, advertising and politics. He suggests that dominant discourse types become 'naturalised', with ideological effects which remain unnoticed because they are seen as "the common-sense way of doing things" (1989: 99). Discourse types are commonly associated with situations but, given the innate 'intertextuality' (Kristeva 1986) of discourse, can, as we have seen (§2.2.1), also occur in new environments. Fairclough regards this spread as colonisation rather than migration and has been particularly concerned to show how public discourse has become increasingly pervaded by discourse types more commonly associated with casual conversation or marketing, to create covert discourses of power. To trace evidence of wider power structures in texts, critical discourse analysts have frequently applied the social semiotic and functional approach introduced by Halliday (1978, 1994), adopting the tri-partite model of field, tenor and mode to explicate every aspect of texts and identify wider social patterns (e.g. Fairclough 2003; Coffins, Hewings and O'Halloran 2004; Young and Harrison 2004).

The relative power of interactants, as exemplified either by general social standing or role-based status, is also thought to be one of the main determinants of the amount of linguistic work which is done to protect either the speaker's or the hearer's face (see Brown and Levinson (1978) 1987). Thus, in the area of face protection too there is scope for complex variation in the interaction between receptionists and patients, since the former have a power which resides in their gatekeeping role yet a low social status within the NHS, while the latter, as already mentioned, have entitlements which should give them situational authority, and may also be able to draw on other forms of status which are part of their transportable identities, and yet, when they request services, create impositions and obligations. The performance of face protection is also affected by other situational factors, as shown in §2.2.4, in which models for analysis of the discourse of face protection are considered.

2.2.4 Politeness

Goffman (1972: 5) defines face as "the positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact". Brown and Levinson (1987: 62) used Goffman's concept as the basis of their extremely influential model of politeness, which divides face into negative wants, "the want of 'every competent adult member' that his actions be unimpeded by others", and positive ones, "the want of every member that his wants be desirable to at least some others". Limitation of either of these wants is perceived as a face-threatening act, in response to which face-saving strategies can be used. Negative wants demand linguistic enactments of formality, deference and social distance while positive ones call for shows of informality, camaraderie and solidarity. Brown and Levinson devised both a formula through which the type of expected attention to face wants could be calculated, setting social power and distance against the degree of imposition in an act, and a taxonomy of the linguistic means which are used to reduce the impact of face-threatening acts.

While the importance of the underlying concepts in Brown and Levinson's work is widely acknowledged, it has been recognised, not least by the authors themselves (1987: 48), that there are shortcomings in their universalist, speaker-centred system (see Arundale 2005; Bargiela-Chiappini 2003). The type and degree of attention to face varies between genders, cultures and nations (Hickey and Stewart 2005; Holmes, 1995; Lakoff and Ide 2005; Spencer-Oatey 2000) and is, as Lerner (1996) shows, an interactionally accomplished phenomenon, emergent in talk rather than the driver of it. In this understanding of it, politeness cannot be evaluated without contextual information, no utterance encodes a specific face meaning and both speaker and hearer are important in the construction of face behaviour. Scollon and Scollon (1995), Spencer-Oatey (ibid.) and Holmes and Marra (2004, following Fletcher 1999) recommend that the idea of positive and negative face be replaced by broader concepts, 'involvement' and 'distancing' in the first case, 'rapport management' in the second and 'relational practice' in the third, while Mills (2003) suggests that the politeness of linguistic acts can only be assessed in relation to their

appropriacy in context, seeing the community of practice as the optimum social unit for such decision-making. Finally, it must also be recognised that "face-aggravation" (Garcia-Pastor 2002), in the form of impolite behaviour or rudeness can also occur (see e.g. Culpeper et al. 2003; Kienpointer, 1997).

An alternative model, which aims to take all these factors into account, has been developed by Watts (2003). Following Eelen (2001), Watts proposes that politeness takes two forms: first-order (im)politeness$_1$, folk or lay interpretation of politeness, and second-order (im)politeness$_2$, the technical sociolinguistic theory. Politeness$_1$ is further subdivided into metapragmatic and classificatory politeness (comments on politeness in interaction) and expressive politeness, which is in evidence when participants make use of expressions such as 'please' and 'thank you', which are institutionalised, ritualised and formulaic. The use of expressive politeness, which is predictable and therefore non-salient, is termed 'politic behaviour' whereas linguistic behaviour beyond what is deemed appropriate is termed polite or impolite, according to whether it occurs at the positive or negative end of the spectrum. In line with anthropological thinking on exchange (e.g. Goody 1972), but acknowledging the influence of Bourdieu (1977b, 1991), Watts therefore prefers to view politeness as a form of linguistic capital or resource which interactants may draw on.

Watts (2003:8) points out that interpretation of linguistic politeness is not at all easy, particularly so since "[t]he term politeness itself is in dispute among lay members of society in that they appear to be engaged in a discursive struggle over the value of the term". However, it also remains the case that some linguistic and pragmatic strategies will be interpreted as more polite than others. Culpeper (2005) has made the following observation about impolite usage which is equally applicable to polite forms: "No act or linguistic expression is inherently impolite but some have a more stable relationship with impolite effects than others". Conventionally impolite expressions, according to Culpeper, include withheld responses, insults, silencers, dismissals, condescension and threats. Polite forms include the formulaic utterances of Watts' expressive politeness, which Aijmer (1996: 51) describes as "small supportive rituals associated with politeness and good behaviour in our society", and

conventionally indirect formulations, such as 'could you possibly help me', which are associated with deference (Fraser and Nolen 1981; Blum-Kulka 1987). The preference organisation of talk can also be used for face protection or aggravation. Lerner (1996), for example, building on Heritage's (1984a: 268) understanding that deviance from the expected preference organisation of talk is an "inferentially rich, morally accountable, face-threatening and sanctionable form of action", shows how anticipatory completions of compound turn construction units are incorporated into the linguistic construction of face protection.

Lerner claims that his findings hold for institutional contexts, as well as familial and therapeutic ones. However, the performance of politeness can also be constrained or changed by the institutional context. Grainger (2002) shows how both institutional roles and contextual factors occasion the negotiation of politeness in hospital geriatric wards. Lakoff (1989), Adelsward (1989) and Penman (1990) have all found that interpretation is affected by the distribution of speaking rights in courtroom discourse while, in contexts such as parliament (Harris 2001; Christie 2002), political debates (Garcia-Pastor 2002), army training (Watts 1992; Culpeper 1996) and exploitative chat or game shows (Culpeper et al. 2003), a face-aggravating stance has been shown to be the norm.

2.2.5 Summary

In this section four areas of research on institutional discourse which have some bearing on receptionist-patient interaction have been highlighted. First, it was shown how the regularities which develop in repeated task-motivated encounters have been analysed. Second, there was a review of approaches to the understanding of the interplay of footings, frames and salient identities which occurs when interactants in institutional-lay dyads enact their roles. Third, there was a review of critical understanding of the constitution and display of power in discourse. Fourth, there was an overview of studies of face protection through linguistic politeness.

2.3 Front desk talk

Many of the points which were discussed in general terms in §2.2 are exemplified in detailed studies of specific instances of institutional discourse. In this section I focus on studies of three forms of institutional discourse which are relevant to front-desk talk. First I review studies of service encounters, second those of institutional gatekeeping and third I draw attention to discussions of doctor-patient encounters from the perspectives of their discourse patterns, the roles and identities of participants and the power asymmetries which develop within them, all features which are echoed in front desk talk.

2.3.1 Service encounters

Lamoureux (1988) has demonstrated that the service encounter is a speech genre which involves a complex process of rhetorical adjustment, with the result that mastery of it can cause difficulty for certain groups (see Myers Scotton and Bernstein 1988; Simounet de Géigel 1990; Togher et al. 1997, 2004; Ventola 1990) while Goffman (1983) chose the service encounter to exemplify and demonstrate his understanding of the micro-constitution of social order. Goffman concentrated on routinisation, the presence of relationship rituals and the contextual combination of local determinism and externally-based attributes, all themes which have been taken up by others. Although Boxer (2002), following Tracy (1997), claims that there is a distinction between service encounters and institutional ones, on the grounds that money changes hands in the former but not in the latter, a receptionist-patient encounter matches the definition of a service encounter by Merritt (see §1.1) and displays many features in common with the studies of service encounters which are described below.

In the first significant work on service encounters, Mitchell (1957) studied the patterns of interaction during street trading in Cyrenaica, to create what McCarthy (2000: 85) describes as “a seminal account of the staging and sequencing of extended spoken events”. Following on from this, Hasan (1985: 64) used the “generic structure

potential" model (see §2.2) to map the "the total range of optional and obligatory elements in their order", while Ventola (1987, 1989) developed flow-charts to account for the occurrence of repetition and recursion in service encounters, focusing on the stages which must, or might, occur before a transaction is completed. Earlier, in a study of encounters recorded in shops on a university campus, Merritt (1976) had analysed the individual moves and turns from which the service encounter is built. She anatomised the exchange structures exemplified by adjacency pairs, insertion sequences and other two or three part units of interaction in microscopic detail.

Merritt drew heavily on the ideas of Goffman, as well as those of conversation analysts, whose insights she both applied and developed. Jefferson and Lee (1981, 1992) also use CA techniques to dissect the genre clash between a service encounter and a troubles-telling, and document the types of constraint inherent in both the form and the content of the genre, while participants in the PIXI project use a CA framework for their cross-cultural comparison of service encounters in British and Italian bookshops. Among their insights are those of Gavioli (1995), who shows that the use of laughter for initiating remedy differs in the two data sets with laughter tending to be turn-initial in English but turn-final in Italian.

In line with work on other genres, there has latterly been a move in service encounter studies away from interest in the distinctive shaping of the exchange structures towards the construction of interpersonal dynamics. McCarthy (2000: 90) is typical in his view that the relational side of discourse in genres, is "of equal relevance to the achievement of goals as the transactional "staging" of predictable elements". Using communication accommodation theory (henceforth CAT) as the basis of their interpretation, Ylanne-McEwen and Coupland (2000: 190) show how speakers in a travel agency "reduce linguistic or communicative differences between themselves and their speaking partners" as they bid to make their communication more effective. Kuiper and Flindall (2000: 184) suggest that, although participants make use of rituals and routines because "there is little room for free and unconstrained linguistic performance in many situations", there is nevertheless "room for individuality,

idiosyncrasy and even for a small measure of creativity" (ibid.: 203). As well as providing further evidence for individual and situational variation, their findings corroborate those of Iacobucci (1990), and Jacobs-Huey (1996), who suggests that nominally relation-oriented talk may be used in the service of task goals.

Linguistic politeness is one of the main tools of the relational side of service encounters and has generated wide interest among researchers interested in cultural variation. Bailey (1997), Mayes (2004), Yabuuchi (2004) and Ryoo (2005) all discover differing norms for the expression of politeness in the speech of different cultural groups in the United States, while, at the other end of the politeness spectrum, Buttny and Williams (2000) discuss narratives of disrespect in inter-racial discourse. In an Asian context, Kong (1998) shows that politeness norms can vary according to the type of encounter, or the anticipated length of a service provider/service user relationship, Pan (2000) that differences in norms can also arise when the same type of encounter takes place in different social settings and Chan et al. (2004) that, although Chinese and Filipino participants in service encounters have different attitudes to rapport promotion, in both cases the client is dependent on the good will of the provider. In South America, Márquez-Reiter and Placencia (2004b) find differing norms of politeness displayed between providers and clients in large stores in the capital cities of Uruguay and Ecuador while, in an earlier study, Placencia (2001), found less respect shown for marginalised social groups than economically strong ones. Placencia (2004) has also conducted a study of rapport-building strategies in a corner shop in Ecuador while, in the European context, both Antonopoulou (2001) using Greek and Bayyurt and Bayraktaroğlu (2001) using Turkish data find that males are less formal and use fewer politeness strategies than females, particularly in more modest social settings.

Although styles of politeness may also vary in multi-national companies, as pointed out in a study of how employees of McDonald's fast-food outlets base their distinctive communicative styles on their different cultural backgrounds (Cook-Gumperz 2001), as Cameron (2000) shows, it is more likely that employees of businesses with a global profile will be asked to communicate using the pre-scripted fake rapport of "synthetic personalisation", which Fairclough (1992: 216) defines as

"the simulation of aspects of interpersonal meaning on the basis of strategic calculation of effects". This simulated rapport may be used because it is thought that female consumers in particular respond more favourably to communality, i.e. a socially-oriented form of service, than a task-dominated one (Iacobucci and Ostrom 1993), although, as Goodwin (1996b) has demonstrated, both marketing variables and differing relationship norms affect consumer responses. Whatever the motivation for pre-scripted relational styles, and despite the fact that they level out social inequalities, Cameron (ibid.) maintains that the imposition of an "ideology of standardisation" (Milroy and Milroy 1991) creates a form of asymmetry in the client's favour based on the worker's enforced denial of self-hood.

There have been only a small number of discourse studies of service encounters involving receptionists. Schneider (1988, 1989) was among the first to recognise the strategic use of small talk in his examination of the language of hotel receptionists. Kidwell (2000) has shown how sequential and institutional contexts provide support for non-native speakers in their interaction with receptionists at a language school and Channell (2000) has engaged in linguistic consultancy work in an attempt to help town hall telephonists to provide a better service. In the health context, Bastos (1996) analysed face-to-face receptionist-client interaction at a health insurance office, finding that linguistic markers of power and solidarity were used differently with receptionists by speakers from different social backgrounds and with differing levels of knowledge of institutional practice. She also noted that clients allowed themselves to be patronised by attendants but not the reverse although, in contractual talk in particular, clients claimed power (and usually achieved favourable results) by attributing requests to authority figures and demonstrating knowledge of administrative procedures or office working practices. Bastos found that the most difficult encounters were those involving "middle employees of accredited medical services" (1996: 168). These clients did not accept the asymmetry in the receptionist's favour whereas low-status clients did. Bastos concludes that her study "is consistent with the assumption that individuals manipulate to their own benefit […] emotional and personal connections in the construction of discourse".

2.3.2 Gatekeeping

GP receptionists are gatekeepers to registration, appointment and repeat prescription services. Erickson and Schultz (1982: xi) define institutional gatekeeping encounters as "brief encounters in which two persons meet, usually as strangers, with one of them having the authority to make decisions which affect the other's future". The essence of gatekeeping work is the legitimisation of membership credentials. Following the lead of Sacks (1992) in his analysis of telephone calls to a suicide prevention centre, conversation analysts have shown in great detail how, when negotiating these claims, both gatekeepers and clients orient to typifications of events and cases. For instance, Zimmerman and his collaborators (Whalen and Zimmerman 1987, 1990; Whalen, Zimmerman and Whalen 1988; Zimmerman 1971, 1992) have shown how communicative frames are used and claims shaped in calls to various emergency services. Among the predictable sequences which they identify are 'epistemological display', in which callers categorise problems and explain how they came to know of the events in question, and 'interrogative series', in which call-receivers elicit all the information necessary for the emergency centre to react to the call. Additional studies of emergency calls include the work of Pérez-Gonzaléz (1998), who refers to the findings of Whalen, Zimmerman and Whalen (1988) but adopts a framework which owes more to the theories of Halliday (1961) and Sinclair and Coulthard (1975). In his close analysis of a call for emergency assistance he shows how the clash between the action-orientation of a caller's turns (the wish for immediate action to be taken) and the knowledge-orientation of the call-taker's stance (the need to elicit essential information from the caller) in the 'service bid' stage (cf Ventola 1987) impedes successful communication between the two participants (see also Marchand and Navarro 1995; Watson 1981).

According to Erickson and Schultz (1982: 25, footnote) "suspicion is institutionalized as part of the official role", which means that clients must demonstrate their entitlement to access. Linell and Fredin (1995: 303), who have shown how this is achieved in a social welfare office, suggest that conflict may develop because "…these verbal exchanges between professionals and clients often

develop into arguing from two different positions, the norms and categorizations of the social welfare and the rationalisation of the clients' everyday life world (Maynard 1988; Cedersund 1992)". They go on to point out that "…it may be that the social worker as a person embodies a negotiation between different identities of his or her self (Taylor 1989) or between different voices within his or her own mind" (1995: 312), speaking at one moment in the voice of the lifeworld, at another, as the voice of the institutional system. Drawing on Zimmerman's (1971) insight that rules are always indeterminate, with no neat fit to reality, they assert (1995: 317) that "abstract categories have to be contextually interpreted" through a negotiation of definitions (e.g. professional jargon v everyday usage) and interpretations, which may even lead to modification of rules and categories because of the "inherent reflexivity between language and its situated use".

The more of an outsider the client, the more difficulty this type of negotiation is likely to present. Many of the most influential studies of the working of gatekeeping practices deal with the cultural barriers which obstruct legitimisation and access. In their work on interviews between academic advisers and students, Erickson and Schultz (Erickson 1975; Erickson and Schultz 1982) have demonstrated how co-membership is constructed on the basis of cultural compatibility, suggesting that "…the [gatekeeping] game is rigged […] in favour of those individuals whose communication style and social background are most similar to those of the interviewer" (1982: 191). They think it possible that "behavioural regularity, especially rhythmic regularity, may be prima facie evidence of shared interpretive frameworks" (1982: 143) and arrhythmia a sign of social disjunction. Gumperz (e.g. 1982a & b, 1996, 1997) has also created an extensive body of reports of gatekeeping encounters, showing how the use and interpretation of linguistic and paralinguistic cues, which vary according to one's first language or cultural background, lead to miscommunication and misunderstanding.

These insights have been applied in the healthcare context by Sarangi and Roberts who have analysed interviews for admission to membership of the Royal College of General Practitioners in a bid to determine why "minority ethnic candidates who had

trained abroad were consistently assessed less positively than their white and ethnic minority counterparts who had trained in Britain" (Roberts 2000: 103). They have found that "[o]ne has to manage to talk like a legitimate participant in order to become accepted in the inner circle, which is characteristic of most gatekeeping encounters" (Sarangi and Roberts 1999c: 68). The problems faced by patients who are non-native speakers are discussed by Cameron and Williams (1997), who, using a relevance theoretical approach, consider the importance both of professional knowledge and the capacity to make inferences for the successful pursuit of instrumental and communicative goals; Frank (2000), who analyses negotiation between non-native speaking patients and English speaking professionals and Angelelli (2004), who is concerned with the effects of interpreter intervention.

The issue of patient access is also the focus of Jean's (2004) study of the gatekeeping (termed 'intake screening') practices of receptionists (termed 'front-office workers') involved in appointment-making in ophthalmology and oncology clinics. Jean concentrates on the variation in interactional styles between restrictive screening practices, which are associated with the rationing of services, and inclusive screening, which is associated with appointment-making after referral. In the former a narrow range of information is considered whereas in the latter the format is open-ended. Jean observes that "[f]ront-office workers typically juggle many tasks simultaneously" and that there is pressure on them because they are accountable for the decisions which they make. Cicourel (2004: 35), who is interested in "aspects of the way levels of medical expertise can influence health care delivery", has also studied the working practices of receptionists in specialist medical clinics. He concludes that receptionists frequently experience cognitive overload resulting either from routine problems and interruptions or "the mismatch between experience, expertise, temperament, the details of a task in hand, and the demands of supervisory personnel" and are obliged to address patient irritation at the mismatch between appointment needs and the lack of personnel to fulfil them.

2.3.3 Doctor-patient communication

Receptionist patient interaction is also part of the broad field of health care communication (see Candlin and Candlin 2003; Gwyn 2002; Heritage and Maynard (in press) 2006; Hydén 1997; Sarangi and Roberts 1999a; Silverman 1997). The view from the consulting room has in the past dominated this field and, as intimated above, in its concern with discourse patterns, the construction of participant roles and the discovery of interactional asymmetries, doctor-patient is the most relevant to this study.

Paul ten Have (2001) suggests that the study of the consultation as a genre is one of the two main topics of interest in studies of doctor patient interaction. Byrne and Long (1976), who were the first to record and transcribe a large number of consultations, found repeated sequences of events, which they classified into six phases, some obligatory and others optional. Their findings are echoed by those of ten Have (1989) himself, who also identified a basic format consisting of six stages. The typical turn-by-turn structure of these stages has received close attention from conversation analysts. Heath (1981), for instance, provides an influential account of the use of 'topic initiators' in the opening phase of the consultation while, in a more recent study, in keeping with the trend towards patient involvement, Gafaranga and Britten (2003) have shown how alignment is achieved, or not, in the joint construction of the first stage of the consultation, and how this relates to the goal of shared decision-making.

According to ten Have (ibid.), the second main topic of interest in doctor-patient talk is discourse style, which is one of the main indicators of participants' understanding of their roles. Strong's (1979) detailed analysis of the role formats used in a large number of consultations in diverse settings is a classic example of this approach. Drawing heavily on the ideas of Goffman, he identifies four formats, or styles of surface ceremony, which participants routinely use. The "bureaucratic format", which, according to Strong, is dominant in NHS clinics, and distinguished on the one hand by impersonality and 'medical dominance', and, on the other, by 'medical

gentility', an idealisation of the patient's personal competence, is contrasted with private, charity and clinical formats, which are present elsewhere. Anticipating Sarangi's (2000) identification of "interactional hybridity" in the context of genetic counselling consultations, ten Have (1989) notes that discourse formats such as therapeutic talk and troubles-tellings, can clash or combine with the dominant clinical one during consultations.

Role formats are interactionally achieved through changes of frame and footing. Coupland and Coupland (2000: 225), who have worked extensively on multi-party consultations in which elderly patients are accompanied by their relatives or carers (see also Coupland, Coupland and Robinson 1992; Coupland, Robinson and Coupland 1994), make the point that "… roles and alignments are not definitely given by the institutional and intergenerational structure of the encounters themselves, although normative configurations are apparent. Non-normative frames can be actively proposed and in some cases resisted". Although frame shifts are a norm of doctor-patient encounters, they may lead to interactional trouble, as Silverman (1987) points out in his demonstration of how teenagers attending a cleft-palate clinic are cast uneasily between everyday and clinical roles as a result of the alternation of consumerist and technical- medical discourses.

Underlying much of this research is the question of asymmetry between clinician and client. Writing of dyadic consultations, Byrne and Long (1976: 29) noted that "in 95% of all consultations studied it may be safely argued that the doctor is in charge of the "how" of that consultation as well as the "what"". Many subsequent studies have concentrated on the mechanisms by which this apparent asymmetry is brought about. Taking a functional approach, Mishler (1984) drew on Schutz's (1962) contrast between natural and scientific attitudes and Habermas's (1984) distinction between symbolic and rational-purposive interaction to demonstrate how personal concerns, 'the voice of the lifeworld', are often stifled by clinical ones, 'the voice of medicine'. Contributors to Fisher and Todd (1983) and West (1984) also find evidence of medical dominance, particularly when the physician is male and the patient female. Specific features which might be thought to construct asymmetry

have also received attention. For instance, Stirling (1999), using data recorded in 1980, shows how if-clauses are mainly used directively in GP consultations, in contrast with their predominantly optative use in other conversational sites, while Shuy (1976) reveals how too great a use of the voice of medicine, in the form of specialist vocabulary, causes problems for patients.

Such views have also been challenged and contested. Meehan (1981) found that problems with medical terminology could be resolved interactionally through repair sequences and Street (1991) that the degree of accommodation in consultations depended on social as well as institutional factors. Both Frankel (1990) and Maynard (1991b) demonstrate how medical dominance is jointly constructed by physicians and patients, illustrating ten Have's (1995: 254) point that "it is best to see [doctor-patient interaction] as a 'strategic game' played in an asymmetrical format; an asymmetry which is constituted collaboratively by both physicians and patients". However, ten Have also conceives of the consultation as a service encounter, in which patients pursue clear service goals through the forms of participation which they adopt, while Hak (2004) proposes that any asymmetry which occurs will be the product not of interactional factors but external, structural discrepancies in knowledge and power. He thus sees asymmetry as a question of orientation to these factors and, as Hutchby (1996: 481, cited in Pilnick 2004: 372) suggests, as a "shifting distribution of resources which enable some participants locally to achieve interactional effects not available to others".

Some of these studies were conducted some time ago and it is probably true to say that, in line with the changes in attitudes to health and illness described in §2.1.1, asymmetry in medical consultations has decreased over the last thirty years, as lay participation in decision-making has become greater and the individuality of the patient better attended to. Both Ainsworth-Vaughn (1998), using data from the US, and Cordella (2004), using material from Chile, suggest that both doctors and patients are able to 'claim power' during dyadic consultations while Iedema et al. (2004) show that the stance of medical personnel in an intensive care unit in Australia goes beyond the technologisation of 'biomedical caricature' (Williams

2001: 140) in its recognition of the human needs of patients. The change in relationships between professional and lay members is also reflected in the increased weight attached to illness narratives, as charted by Hydén (1997) and illustrated by Greenhalgh and Hurwitz (1998). This has also had an impact on treatment, as Candlin and collaborators (Candlin 2000, 2004; Candlin, Moore and Plum 1998) show in their finding that, for patients with HIV/AIDS the discourse mechanisms of concordance, which involve the sharing of information, responsibility and agency, produce better medical outcomes, than those of compliance, in which the patient adheres to the treatment regime prescribed by the medical professional.

However, although research on the use of less clinical communicative styles has shown how they can both improve health care and make the patient more comfortable (e.g. Ragan 1990, 2000), it is apparent that a socially interactive posture may also be exploited as an alternative route to medical control (Silverman 1987) and that negative evaluations of patients can be constructed using relational discourses (Kovarsky, Duchan, and Maxwell 1999). In addition, physicians may still find it difficult to accept patient involvement in decision-making (Warren, Weitz and Kulis 1998) with the result that the prototypical pattern of interaction, at least in primary care in the UK, still appears to be the one identified by Skelton, Wearn and Hobbs (2002) in their concordancing analysis of the use of first person pronouns: "Patient: I suffer. Doctor: I think. We will act".

Although they serve very different purposes, as will be seen, there are many parallels between doctor-patient and receptionist-patient encounters, both in the structure of the individual stages, as pointed out to me by a GP (name not known) who commented on the findings of my research, and the asymmetrical positions which are often adopted.

2.3.4 Summary

In this section an outline has been given of three areas of discourse research which have some bearing on receptionist-patient discourse. First there was a review of

studies of service encounters, including those involving receptionists, in which it was shown that both transactional and relational elements have been found to contribute to the distinctive characteristics of the genre and that there are considerable variations in the use of linguistic politeness strategies in different social and institutional contexts. Second, there was a discussion of gatekeeping practices, in which it was shown that institutional participants regulate entry and lay ones negotiate it through orientation to displays of entitlement to co-membership. Third, there was a review of a number of features of doctor-patient encounters which find parallels in receptionist-patient talk. These included their transactional staging and the presence in them of different discourse frames and varying levels and forms of interactional asymmetry.

2. 4 Research and training

One of the primary reasons for conducting this study was the realisation that there was little research on receptionist-patient interaction in general and no studies of front desk talk in the NHS. It had also been noted that training opportunities for receptionists tend to be limited and that naturally occurring examples were not available for use in such courses as did exist. This led to the intention to explore how findings from the study might be used to inform receptionist training. However, the question of whether and how discourse analytical data can or should be used for the training of institutional members has been subject to discussion. The different conclusions which have been reached will be reviewed in this section.

Sarangi and Roberts (1999b: 39) describe the two main possibilities for the use of discourse research: either "research studies are irreducible and should not be boiled down for practical use" or "research must be done first and then the boiling down can follow". Sarangi and Candlin (2003b) draw attention to the difficulties faced by the discourse researcher who is asked to act as an impartial and distant observer but simultaneously to be a consultant, evaluator and assessor, pointing out that expert findings are always uncertain and should not therefore be applied directly to practice. This is particularly so because of the analyst's status in healthcare contexts which,

Candlin and Candlin (2003) suggest, may limit insider knowledge and reduce understanding of professional practice unless there is full collaboration from the researched group. However, collaboration may lead to an additional problem: the exploitation of the analyst in the name of managerial and bureaucratic agendas. Fairclough (1992: 238) also warns against these risks, suggesting that "[d]iscourse technologization is a resource for cultural and social engineering", while Cameron (2000a: 71-72) shows how over-prescriptive approaches to training develop because of "a widespread belief among managers that linguistic regulation can be used systematically as an instrument of culture change and control over people".

Fairclough (op. cit.) nevertheless accepts that research can be used to inform training and proposes that, instead of being used for top-down enculturation into new discourse practices, specialist knowledge be used to facilitate change from below through teaching of "critical language awareness" (CLA). Candlin (2000: 242-243) adopts a similar position in her recommendations for the training of nurses, calling for "the re-articulation of a new configuration" in order that nurses "develop a critical and explanatory awareness of the power potential of discourse". Erickson and Schultz (1982: 205-210) also support the use of authentic examples, suggesting that they can be used to raise critical awareness of the effects of "particularistic features". However, they recognise that generic good and bad styles cannot be clearly defined and that, when research does lead to training, the latter must not be over-prescriptive but responsive to the interactional environment. Hydén and Mishler (1999) exemplify this point in their demonstration of the ineffectiveness of medical training based on generalisations while Silverman (1992) shows how the use of 'real-life' examples helps to prevent the pitfalls of anecdotalism and over-abstraction.

It is also recognised that, in situations where there is gatekeeping or institutional-lay contact, knowledge based on authentic data can be particularly useful. For instance, Kaspar (1990: 208) sees the importance of observing cultural variation "especially […] in gatekeeping encounters as one precaution against discriminatory practice", proposing the use of discourse strategies such as an increased amount of small talk to promote co-membership, while Gumperz (1982b) has used his research on cultural

variation and the conventions behind the use of contextualisation cues as the basis for programmes which increase awareness of cultural difference.

Another feature of authentic discourse, which is sometimes lost when invented rather than attested examples are used, is its complexity. Ventola (1990: 502) has made comparisons of her service encounter data with textbook examples to introduce language learners to the complexity of real-life communication, increasing attention, for example, to strategies which increase rapport and thus "decrease the discomfort of the participants greatly by decreasing social distance". As Aston (1995: 80) comments, "[t]eaching needs to focus not only on underlying regularities of sequential structure, but also on the ways in which things can be worked out when the instantiation of those scripts is problematic for participants in the talk".

The inductive method has been successfully applied in a number of disciplines. In English language training, Carter and McCarthy (1997, 2000) have produced textbooks using only attested examples. In medical training, Roberts et al. (2003) have used their findings on the differences between the discourse styles of undergraduate medical students as the basis for a proposed new teaching framework. Togher et al. (2004) have used research findings to devise a training scheme designed to improve communication between police desk officers and clients who have suffered traumatic brain injury. Finally, in civic administration, Channell (2000) has created a discourse-based awareness-raising programme for town hall receptionists, with the aim of increasing both their efficiency and their customer relations skills.

In sum, although there are difficulties resulting either from the conflicts between the research goal of objectivity and the need for evaluation or from the risk of exploitation by institutional members, there are a number of reasons for using the findings from discourse analysis for training. These include the avoidance of over-abstraction or idealisation and the raising of awareness both of cultural variation and the complexity of naturally occurring interaction.

2.5 Summary

In this chapter I have reviewed:

- sociological theories of health care and their relationship to current NHS practice;
- studies of receptionists and their work;
- the theoretical models which have been used to analyse the discourse patterns, roles and identities which are salient in institutional-lay encounters;
- approaches to power and politeness in discourse;
- three forms of talk - service, gatekeeping and doctor-patient encounters - which share features with front desk talk;
- attitudes and beliefs about the use of discourse data for institutional training.

In the next chapter I turn to the methodology on which this study is based and the methods which were used to apply it.

Chapter 3

Research methodology and method

3.0 Introduction

Although, like all cultural representations, research studies are constructs which are shaped to some extent by the current interests, theories and methods of the researcher (see e.g. Denzin and Lincoln 1994; Potter 1995), as Atkinson, Coffey and Delamont (2003) suggest, this does not preclude the systematic analysis of the structures and patterns through which action and interaction are encoded. This study is qualitative, in the sense that it is an attempt to identify the patterns and meanings which underlie naturally occurring episodes of interaction, but it also aims to meet the rigorous standards necessary to ensure the validity, reliability and objectivity of the findings. These are clearly defined by Denzin and Lincoln:

> … *internal validity*, the degree to which findings correctly map the phenomenon in question; *external validity*, the degree to which findings can be generalized to other settings similar to the one in which the study occurred; *reliability*, the extent to which findings can be replicated, or reproduced, by another inquirer; and *objectivity*, the extent to which findings are free from bias.
> (1994: 100)

In order to meet these criteria, decisions have to be made about the method of sampling, the organisation of data and its contextualisation, the three points which Daly et al. (1992b) consider to be the basis of generalisability in qualitative work. Consideration also has to be given both to possible obstacles to reliability and validity and to the requisite research ethics. In the present study it was also necessary to take into account the difficulties which can arise in cross-disciplinary work.

Mays and Pope (2000: 95) point out that, in qualitative research, the clear exposition of one's methodology is vital because "the methods used in research unavoidably influence the objects of enquiry". The methodology for this study will be discussed in the first section of this chapter while in subsequent sections the six clearly defined phases of the research will be described. These are:

1. Obtaining permission to carry out the research from NHS bodies;
2. Recruitment of GP practices;
3. Familiarisation with participating practices and organisation of ethnographic information;
4. Recording of interaction at front desks;
5. Transcription and analysis of recordings;
6. Implementation of findings in receptionist training.

3.1 Methodology

3.1.1 Method of sampling

To answer the research questions satisfactorily, it was essential to obtain examples of naturally occurring interaction from the front desks of GP practices. By "naturally" here I mean talk which is not the product of experimental conditions but would occur, in some form, regardless of the presence of a researcher or recording equipment[8]. Both audio and video recording allow us "to document members accounting to each other in natural settings" (Dingwall 1997: 60). Although the analytical possibilities would be much diminished by the absence of visual evidence (see Heath and Hindmarsh 2002), it was thought that audio would be the more suitable medium for this research since it would cause less disruption in an environment where sensitive matters were being dealt with. It would also be less expensive, a consideration which was always important in a research project for which very little funding was obtained[9].

The qualitative researcher's approach to triangulation, the comparison of results from two or more sources, whether of data, method, analyst or analyst-participant (Denzin 1978), dictates the sampling strategy which is adopted. Although triangulation of

[8] For discussion of the term "naturally occurring interaction", see Speer, ten have, Lynch and Potter (2002).
[9] PhD fees for two years were covered by a University of Edinburgh Standard Award but applications to the Economic and Social Research Council, the Chief Scientist Office, Scotland, and Lothian Primary Care Research Network were all unsuccessful.

data sources may be thought to ignore "the context-bound and skilful character of social interaction" (Silverman 2001: 235), as Mays and Pope (2000: 94) point out, it ensures "the comprehensiveness of a set of findings". It was therefore decided to seek data from a range of GP practices with different social and demographic profiles, making the sampling purposive with regard to number and type as well as setting. On the assumption that it is necessary for the researcher to report plenty of instances (Silverman 2000), it was also decided to record a minimum of 40 episodes of interaction from each practice to give a total of at least 120. It was thought preferable that all the practices sampled be part of the NHS. Inclusion of one of the very small number of private GP practices was considered, on the grounds that they could be treated as negative or deviant cases, which might shed light on standard NHS practice since "to establish a rule's universality one needs to examine those occasions when it is most seriously tested" (Strong 1979: 233). This idea was eventually rejected because both the procedures and the activities of private GP practices are different from those of the NHS (Dr Ninian Hewitt, personal communication)[10].

3.1.2 Organisation of data

To avoid the charge of anecdotalism, data must be organised systematically. Silverman (2001: 238-241) asserts that the five most important techniques in qualitative data analysis are:

- analytic induction
- the use of the constant comparative method
- the search for deviant cases
- comprehensive data treatment
- using appropriate tabulations.

Using these methods, the researcher will approach the data with a general idea but no firm hypothesis, generate a hypothesis from the data by analytic induction, as in

[10] Private GP practices do more preventative medicine and use different types of documentation.

grounded theory (Glaser and Strauss 1967), test the hypothesis repeatedly on all the data, assign the data consistently to categories, identify deviant cases, i.e. cases which a hypothesis does not account for, review the hypothesis in terms of the underlying model in order to account for the deviant, or negative, cases. This approach will also allow the researcher to use "appropriate tabulation", i.e. to create a comprehensive taxonomy and to count instances of any phenomenon. By this means the qualitative approach does not have to be seen as the antithesis of a quantitative one since, as Hammersley (1992: 163) points out, "[w]e are not […] faced with a stark choice between words and numbers, or even between precise and imprecise data; but with a range from more to less precise data".

These were, broadly speaking, the analytic methods used for this study. Front desk discourse activities and types were identified, and then classified into groups and sub-groups until all instances were accounted for. Both recordings and transcripts were also subject to continuous review as new categories emerged. The analytical frameworks introduced in §1.3 were then applied to each category and discourse patterns identified and accounted for.

3.1.3 Contextualisation

Almost a century ago Malinowski (1923: 464-465) observed that "[l]anguage is essentially rooted in the reality of culture" and that interpretation depends on the "context of situation". As Linell and Luckmann (1991: 1) point out, "there is considerable disagreement […] as regards how and to what extent analysts should bring contextual information to bear on the process of identification and interpretation of discourse patterns". Debate has been ongoing (see Duranti and Goodwin 1992) and sometimes fierce (e.g. Schegloff 1997b, 1998; Wetherell 1998) about the admissibility of contextual information in analysis and the means of using it. Proponents of the top-down approach believe that "[t]he site in which a text occurs typically contains instructions as to how it should be read and what meanings should be found in it" (Hodge and Kress 1988: 68) while, at the opposite end of the spectrum, conversation analysts such as Schegloff (1991) believe that context must

always be endogenously produced, something which is oriented to and made 'procedurally consequential' by participants in their talk.

My own position is close to that of Sarangi and Candlin (2003a: 281), who believe that "ethnographic observation can be a rich resource for validating discourse claims", and of Sarangi and Roberts (1999b), who suggest that there are four contexts which may be relevant in an analysis:

- the immediate social and physical setting;
- the behavioural environment and the non-verbal use of space;
- the linguistic co-text and the contexts called up in discourse;
- the wider, extra-situational, social, political and cultural background.

Although my ideas about the nature of context evolved in the course of the study, my aim when the research method was being developed was to provide a full ethnographic description, which would cover all the contexts mentioned by Sarangi and Roberts. Background reading would build up my understanding of the social, political and cultural contexts. A period of observation at each practice would serve to familiarise me with local procedures and a research diary would cover the social, physical and behavioural contexts of situated discourse activity. Semi-structured interviews (Spradley 1979) would also be conducted with participating receptionists (see §3.5.2 for interview questions and findings). They would be informal in style, with the dual intention of inspiring confidence and promoting rapport. In addition I hoped to obtain some information about patients, who would be spending only a short time in practices, by handing out four-point questionnaires, asking for details of age, sex and practice attendance patterns. A further form of contextualisation was also planned in the form of feedback sessions to receptionists at all participating practices. It was thought that these would both give back something to the organisations in exchange for their contributions (see also §3.1.5) and provide opportunities to test pedagogical approaches to the use of the research findings in receptionist training.

3.1.4 Ensuring reliability, validity and objectivity

Silverman (2000) observes that, as long as standard, and detailed, transcription techniques are used (see §3.6.1), data in the form of text are, unless forged, already more reliable than many other qualitative data sources. However, it is also advisable to ask other analysts to verify one's findings to achieve inter-rater reliability. Although, for example, both Armstrong et al. (1997) and Daly et al. (1992b) have demonstrated the effectiveness of such verification in studies of healthcare practices, the only form of analytical cross-referencing which it was possible to attempt for the current study was through discussion of working papers at seminars and conferences. However, to compensate for this, there is detailed documentation of data collection and transcription procedures.

Another form of authentication is respondent validation, the checking of results by participants. Mays and Pope (2000: 95) conclude that this is of limited value because "the account produced by the researcher is designed for a wider audience and will, inevitably, be different from the account of an individual informant". Also, as Fielding and Fielding (1986: 43) observe, "there is no reason to assume that members have privileged status as commentators on their actions", in the sense that their views are always more valid than those of expert analysts. However, as Erickson and Schultz (1982) and Cicourel (1992), for example, have shown, the participant perspective can give ecological validity to the data, both by clarifying interpretations and by confirming analyses. This is particularly true in contexts such as the healthcare one of the present study, where the discourse may include specialist talk, which cannot immediately be understood by an outsider. It was therefore decided to seek a minimal amount of respondent validation, in the form of requests for clarification of meaning from receptionists when specialist knowledge was displayed.

Researchers must also be aware of possible causes of bias. First, there should be vigilance regarding how the research method might have influenced the data. This is Labov's "Observer's Paradox", which states that "…the aim of linguistic research in

the community must be to find out how people talk when they are not being systematically observed: yet we can only obtain these data by systematic observation" (1972b: 209). Second, there is a need for researchers to be aware of their own intellectual positions. This can be thought of as 'fair dealing' (Dingwall 1992), the avoidance of the representation of the views of one group as the sole truth of a situation. The reflective approach adopted in this study recognises these methodological "catch-22s" and tries to mitigate them by commenting on possible effects in the case of the first point and by making extensive reference to existing studies in the case of the second.

3.1.5 Cross-disciplinary research

The systematic collection of data from face-to-face interaction generates a certain amount of resistance and tension whatever the environment, since normal behaviour patterns are inevitably disrupted. As anthropologists and ethnographers have shown (e.g. Agar 1980; Geertz 1973, Spradley 1980), this is particularly true when the culture to be researched is unfamiliar to the researcher, or the world of the researcher unknown to the researched. Furthermore, even when the researcher successfully negotiates access to an unfamiliar cultural environment, there remains the difficulty of developing and sustaining relationships with collaborators and subjects within the researched community while simultaneously maintaining objectivity and attempting to avoid bias. All these problems are as salient in cross-disciplinary research, which bridges academic or institutional boundaries, as in research which involves the crossing of social or international borders. As Myers explains:

> Disciplines are like cultures in that: their members have shared, taken for granted beliefs; these beliefs can be mutually incomprehensible between cultures; these beliefs are encoded in a language; they are embodied in practices; new members are brought into the culture through rituals. (1995: 5)

Discourse research in healthcare settings is an example of such cross-disciplinary research.

The problems faced by discourse specialists when undertaking research in healthcare environments have been examined in depth by Sarangi and collaborators (Roberts and Sarangi 2003; Sarangi 2002; Sarangi and Candlin 2003a and 2003b; Sarangi and Roberts 1999; Sarangi et al. 2003). These are summarised in an editorial in *Communication and Medicine* in which Sarangi reflects on the challenges he has faced as "a communication researcher committed to the crossing of professional boundaries in medical and healthcare settings" (2004: 5). I have organised his comments under three headings in order to reflect their relevance to the present research[11].

1. *Differences between disciplines*

The first problem for the discourse researcher working in a medical context is the unfamiliarity of the discipline of discourse analysis within medical circles. This generates difficulties at several levels. First, there is confusion surrounding the term 'discourse analysis' and a difficulty in grasping exactly what form of expertise it describes. Sarangi (2004) reports how, even after referring to himself for some time as a 'discourse practitioner' (see Sarangi 2002), "I continue to be labelled as a 'psychologist'. In a sense, this shows how from a (bio)medical perspective, the different humanistic and social scientific disciplines may be regarded as one residual category with different manifestations".

This inappropriate labelling also implicitly reveals a second problem faced by the discourse researcher: the need to demonstrate the value of discourse research and the relevance of its findings. Sarangi again provides perceptive analysis in his comment on the reaction of a colleague from the medical world to the transcript of a counselling session she has given:

> By questioning the very data which the discourse analyst has to use to substantiate his/her knowledge claims, the professional practitioner is not only challenging the linking of data transcripts as direct evidence of discoursal claims, he or she is

[11] Sarangi has actively collaborated with medical researchers as well as carrying out his own discourse research in healthcare settings. The present study has involved only cooperation, rather than collaboration, with researchers from the medical community.

> already distancing himself or herself from the research outcomes and their trustworthiness. (2004: 7)

Underlying this type of resistance to the tools of the discourse analyst and, by extension, to the claims of discourse analysis itself, is perhaps the contrast between the dominant paradigms of linguistics and of medicine. It has been suggested, for example, that there has been a preference in the medical world for quantitative methodologies and a distrust of qualitative research on the grounds that it is unscientific, subjective or anecdotal (Pope and Mays 2000b).

When the gulf between disciplinary cultures is great, as it is between what Sarangi terms 'humanistic and social scientific' and '(bio)medical' perspectives, the representatives of one culture will be resistant to the expertise of those from another. Disciplinary cultures are constructed partly by their different discourse styles (see e.g. Candlin and Hyland 1999, Flowerdew 2002, Hyland 2002; Veel and Martin 1998). This difference between discourse styles can lead, in its extreme form, to a third problem for the discourse researcher in the medical world: the mutual unintelligibility of vocabularies which may, as Cicourel (1992; 2003) has shown, manifest itself as an overt absence of understanding or, more insidiously, remain below the level of awareness since "[l]exical phrases always carry tacit assumptions associated with local interaction" (2003: 363). This means that, in order for satisfactory levels of mutual comprehension to be achieved, as Clarke, a medical geneticist, suggests, both researcher and researched must have "a willingness to put an effort into active engagement in the collaboration" (2003: 384).

2. *Relationship between researcher and researched*

Sarangi also comments on the need for a positive relationship between researcher and researched. Basing his conclusion on the work of Cicourel (1992), Clarke (2003) and Candlin (2003), he suggests that, to resolve comprehension problems, "[t]he 'communicative mentality' in the professional sphere needs to be matched by the communication researcher adopting a 'clinical mentality' […]" (2004:5), something which requires that positive working relationships are developed between researcher

and researched. Relationships are not always easy to develop, partly for the reasons described above but also because the researched group may feel threatened, particularly if they have played no part in making the decision to host the research and feel that they are being judged or assessed. The development of relationships may also require diplomatic skills on the part of the researcher since, as Cicourel (2003: 369) observes, "every organisation has its political and social divisions" and "principal investigators must always walk a delicate line between different factions".

Even when relationships are successfully developed and maintained, researchers must be wary of their impact on results since, according to Sarangi (2004: 7), in institutional research environments, in addition to 'the observer's paradox', two other possible sources of distortion must be considered. First there must be awareness that participants will be affected in different ways by different observer styles or levels of involvement. Second, there should be acknowledgement that the observer's dependency on interpretative input from expert insiders may lead to distortion if the latter provide unsatisfactory or inadequate information, or if their comments are wrongly understood.

3. *Differing expectations*

The institutional setting of healthcare research also generates one more set of pressures. The NHS is no exception to the general rule that those working in organisations are subject to economic constraints. When research is carried out in such settings there is an understandable expectation that, in Holmes and Stubbe's (2003: 20) words, the researched group will receive both "long-term results" and "a more immediate concrete benefit in return for the goodwill". In short, it is expected that research will have outcomes which "can be applied to solving practical problems" (Sarangi and Roberts 1999b: 39). This creates two areas of difficulty. First there is the pressure associated with delivering results in a suitably practical format: the need to make discourse findings comprehensible and plausible to a non-specialist audience; to ensure that any diagnostic comments are tactfully presented; and to show due respect for the experience-based expertise of the researched. Secondly

there is the risk that academic freedom and the advancement of theoretical understanding will be prejudiced by the constraints of delivering outcome-based findings. One might add to these points the pressure which researchers feel when they are placed in the role of expert consultant by professional insiders (see Sarangi and Candlin 2003: 280).

3.1.6 Research ethics

Ethical issues also underpin all relationships between researchers and researched. All research in NHS settings is subject to strict ethical control and must first be approved by Research Ethics Committees (Central Office for Research Ethics Committees 2004), which are there to ensure both that patients are protected and that the research complies with The Data Protection Act (1998). Research Ethics Committees ensure that proposals to carry out research in healthcare contexts are given careful scrutiny, covering issues such as scientific responsibility, informed consent, confidentiality and anonymity for participants, but do not specify in detail how interpersonal matters should be dealt with when research is in progress. The conduct of relationships with researched groups should be a fundamental concern for all researchers. Consequently, before this study began, I asked myself several questions on this point.

1. What approach is the researcher to take towards the researched?

Cameron et al. (1992) summarise the alternative positions which can be adopted by the researcher as research on, research for and research with the researched. They see research on as complying with basic ethical requirements by having "a wholly proper concern to minimise damage and offset inconvenience to the researched, and to acknowledge their contribution" (1992: 14), research for as a form of advocacy in which "a researcher is asked to use her skills or her authority as an 'expert' to defend subjects' interests" (1992: 15), and research with as a route to the empowerment of the researched in which there is "active co-operation, which requires disclosure of the researcher's goals, assumptions and procedures" (1992: 23). It was my intention, at the very least, that my research should meet the basic ethical requirements of

research on but I hoped that it would also in a real sense be research for and with both receptionists and patients, and a contribution to improved conditions for both groups.

2. What type of relationship will the researcher have with the researched?

In line with my preferred research stance, I aimed for a relationship of trust and cooperation with the researched groups, in which nothing would be done without their involvement and approval. This ideal position proved difficult to sustain. I had no direct contact with members of one researched group in my recordings, the patients, while members of the other, the receptionists, were often either too busy to provide any direct input into the research or simply not given the necessary time by their managers. In addition, just as the borderline between overt and covert recording can become blurred, (for example, when recording is already in progress and researchers are loath to interrupt the flow of a discussion to explain to later arrivals that equipment is running (Milroy 1987:89)), so the transparency of relationship between researcher and researched can easily become murky, often because there is insufficient time to explain procedures in detail.

3. How will the research affect the researched?

Milroy (1987) points out that a permanent record of some kind can easily affect the subject's self-image. This is particularly true of linguistic transcriptions which, as well as being impenetrable to the untrained reader, can give undue salience to verbal behaviours of which those using them may either be unaware or judge pejoratively. To counteract this possibility I hoped to talk about transcriptions privately with each receptionist who was involved. (This would also have applied to patients had any of them asked to see transcriptions.) Participants may also feel exploited by researchers who establish relationships from which they disengage as soon as the required data have been obtained. Because of this, Cicourel (2003) suggests that disengagement should be handled with care. Again, the nature of my study meant that I would not establish relationships with patients but that contact with receptionists would be

ongoing. My aim was to consult all those involved before any use was made of data collected at their practices and to report back to them about the reaction to conference presentations, published papers and so forth.

4. Does the researcher have a debt to the wider community?

This is another issue raised by Milroy (1987) and also, specifically, by Rickford (1997) who cites Labov's view that "[an] investigator who has obtained linguistic data from members of a speech community has an obligation to use the knowledge based on that data for the benefit of the community, when it has need of it. (1982: 173)". My own research had a very obvious potential payback to the community in the form of the training which could be given to receptionists. I also hoped to speak to groups of patient representatives so that the insights of the study could be shared with service receivers as well as providers. I was aware that in doing this I would have a responsibility to make the findings intelligible to lay people, who can be seriously disturbed by misinterpretation of expert knowledge, particularly in the medical context where health fears may already be prevalent.[12]

To conclude, it was within the compass of the institutional and ethical constraints described above that the research methods described below were formulated and applied.

3.2 Institutional authorisation

Before data could be collected, authorisation had to be obtained from a number of bodies and groups within the NHS. Their remit was to ensure that the research would not pose any risk to their organisation or to their patients and to ensure that the results could be of practical value to staff or patients.

[12] In her presentation at the SSPC 2002 conference Hilda Bastian, convenor of the Cochrane Collaboration Consumer Network, cited the case of a patient who failed to understand that her health was good when told that test results were negative. The patient commented: "I had negative results and I was so scared". I have observed that mention of negative politeness can have a similarly confusing effect on a non-specialist audience.

3.2.1 First contacts

The process of making contacts within the NHS, of building up working relationships and developing mutual understanding, was, as predicted by others working in unfamiliar institutional environments, a slow one which demanded both patience and determination. At this stage, and indeed throughout the period of my research, I was dependent on the goodwill of individuals already working in the NHS and consequently always felt that it was important to make the best possible impression on the people I encountered. This was an illustration of the point made by Hammersley and Atkinson (1983:73) that people "are often more concerned with what kind of *person* the researcher is than with the research itself" (emphasis in original). My first contacts were with an experienced GP, who had been involved in research and training for many years, and with the director of The Scottish School of Primary Care, an organisation with the remit of promoting primary care research throughout Scotland. Through them I was introduced to the Network Co-ordinator of Lothian Primary Care Research Network (LPCRN), who supported my work by facilitating contact with NHS personnel and overseeing the drafting of my application to the Research Ethics Committee.

3.2.2 Writing the research proposal

I spent the first three months of 2002 developing a methodology which would both allow me to answer my research questions and comply with the requirements of the Research Ethics Committee. Before drafting the proposal, I had first to improve my knowledge of a number of aspects of the NHS in Scotland. These included:

- health policy;
- organisational structure;
- research culture;
- organisation of general practice;
- research in general practice;
- GP receptionists and their work.

Although much of this information was available in written form in NHS publications and in the research literature, I also made direct contact with NHS managers, who provided information about policy priorities and the organisational structure of general practice, and observed the day to day running of a GP surgery by spending some time with receptionists in a training practice. All this consultation was reflected in the research proposal - or protocol, in the terminology of healthcare research - which was redrafted several times before its applied linguistic aspects were thought to be accessible to a primary care audience.

The research proposal (see Appendix 6, p.479) had to satisfy the research ethics committee on four main counts. It had to show:

- that the research was of scientific value;
- that subjects would be recruited using appropriate procedures;
- that subjects would be provided with sufficient information for them to give informed consent to take part in the study;
- that the confidentiality and anonymity of subjects would be maintained.

There follows an outline of how the research proposal attempted to cover each of these points.

i) *Scientific value of the research*

In the context of the NHS, the scientific value of research has to be related to current policy objectives and to have potential outcomes which will be both practicable and cost effective. The year 2000 saw the publication of the long-term policy document of the new Scottish Executive *Our National Health: A Plan for Action, a Plan for Change* (Scottish Executive 2000a). Two of the core aims projected in this document were to "achieve better, fairer access to services" and to "improve communications and break down barriers" (Section 4). The research proposal was therefore formulated with an emphasis on these factors. It was also shown through a literature

review that the work would add to existing knowledge of the field[13], and a case was made for the validity and reliability of the qualitative methods to be used. This included a demonstration that the interaction would be recorded at contrasted sites which would make it "typical of the routine communicative practices of the organisational settings being studied" (Cicourel 2003: 263); an estimate of the size of sample which would be obtained; and a description of how the recorded data would be supported by an ethnography. Finally, it was noted that the project had been critiqued by members of the Lothian Primary Care Research Network.

ii. *Recruitment of subjects*

It was proposed that subjects be recruited by self-selection, that is, by opting in if attending practices while the study was in progress. The protocol also stated that individuals who were not competent to provide consent would be excluded. This would include young children and patients covered by the Adults with Incapacity Act 2000[14].

iii. *Arrangements made to obtain the informed consent of subjects*

First, an information sheet was written (see Appendix 6, p.482), in which the aim was to cover the following points:

- Research method
- Assurance of confidentiality and anonymity for both practice and participants
- Use of results
- Research timetable
- Opportunity for retrospective opt-out
- Name and contact details of Independent Adviser[15]
- LREC certificate number

[13] The literature on which this aspect of the proposal was based has already been reviewed in detail in Chapter 2.
[14] The one patient in this category was identified by a receptionist and not asked to give consent.
[15] The Independent Adviser is a neutral observer who monitors a study and whom participants may consult if they have any queries or concerns about it.

Second, an undertaking was given to obtain the written consent of all participants. Staff members were to be approached before the audio-recordings were made and patients were to be asked to give their consent after they had spoken to receptionists. This meant that a research assistant would be needed to accompany the lead researcher, myself, to practices. The assistant would be there to explain the information sheet and seek the written consent of patients while the lead researcher monitored the audio-recording at the counter. It was also agreed that, if necessary, the information sheet would be translated into Hindi, Bangladeshi, Urdu and Chinese, the four most widely spoken minority languages in Lothian[16], and that patients making telephone calls to the practices would be asked at the beginning of conversations if they were willing to be recorded for research purposes and, if their answer was yes, would receive consent forms to return in stamped addressed envelopes.

iv. *Maintaining confidentiality and anonymity for subjects.*

It was noted that the study would involve some intrusion into the privacy of subjects as notes would be taken and recordings made of potentially sensitive and confidential verbal transactions. However, an undertaking was made that only the principal researcher would have access to the recordings and no personal or practice names would be used when transcriptions were made of the interaction. A guarantee was also given that all recordings and notes would be kept in a secure environment during the period of transcription and analysis and destroyed when the analysis had been completed.

3.2.3 Obtaining authorisation

Since it was proposed to conduct this research in GP practices in the Lothian area, a request for ethical approval was made to the sub-committee of the Lothian Research Ethics Committee (LREC) which deals with applications to carry out research in

[16] In the event, this was not necessary.

primary care settings. The LREC application form was a 26 page, multi-purpose document which was used for all types of ethical review, including those of research entailing bio-medical intervention. Seventeen copies of the application were lodged with LREC and a decision was made when the committee met on 11th April 2002. The application was not approved but I was given the opportunity to meet committee members briefly in order to discuss the grounds on which they had rejected my application. Their main objection was to my wish to obtain the consent of subjects retrospectively (in order to ensure that the interaction was as natural as possible). This request was found to be unethical and to contravene the Data Protection Act 1998.

In the wake of this rejection I canvassed a wider range of opinion within NHS Scotland, including delegates to the Scottish School of Primary Care annual conference, a professor of general practice, an organiser of training courses for receptionists, the representative of a patient-involvement group and GPs, nurses and sociologists attending meetings of LPCRN. The upshot of all this consultation was a revised research plan which addressed the questions asked by LREC more rigorously. A second application was submitted to LREC on 5th September 2002. This time I was invited to appear before the committee when it met on 20th September 2002 to consider the application. Approval of the project was subsequently granted on the understanding that several additional points were included in the research design, notably that:

- The researcher should not be able to overhear interviews for which consent had not been granted.
- Patients should be advised that withholding their consent would not affect the treatment which they receive.
- The numbers of patients who declined to participate, as well as those who did, should be monitored in order to give clarity as to the applicability of the research findings.

The research design was duly modified and a Certificate of Ethical Opinion was issued on 2nd October 2002. Applications were then made to two Lothian Primary Care Trusts, the NHS administrative bodies responsible for general practice in the area, for permission to proceed with the research. Approval came from Lothian Primary Care Trust in November 2002 and from West Lothian Primary Care NHS Trust one month later. Finally, a guarantee of insurance cover was obtained from the University of Edinburgh.

3.3 Recruitment of practices

General practitioners were approached individually and asked if they would be willing to host the research. If the response was positive, contact was made with practice and reception managers and a letter sent to receptionists explaining the nature and scope of the study. This was done to ensure that the research would only be carried out if there was still consensus that it should go ahead after all potential participants had been informed about the research method.

3.3.1 Choice of practices

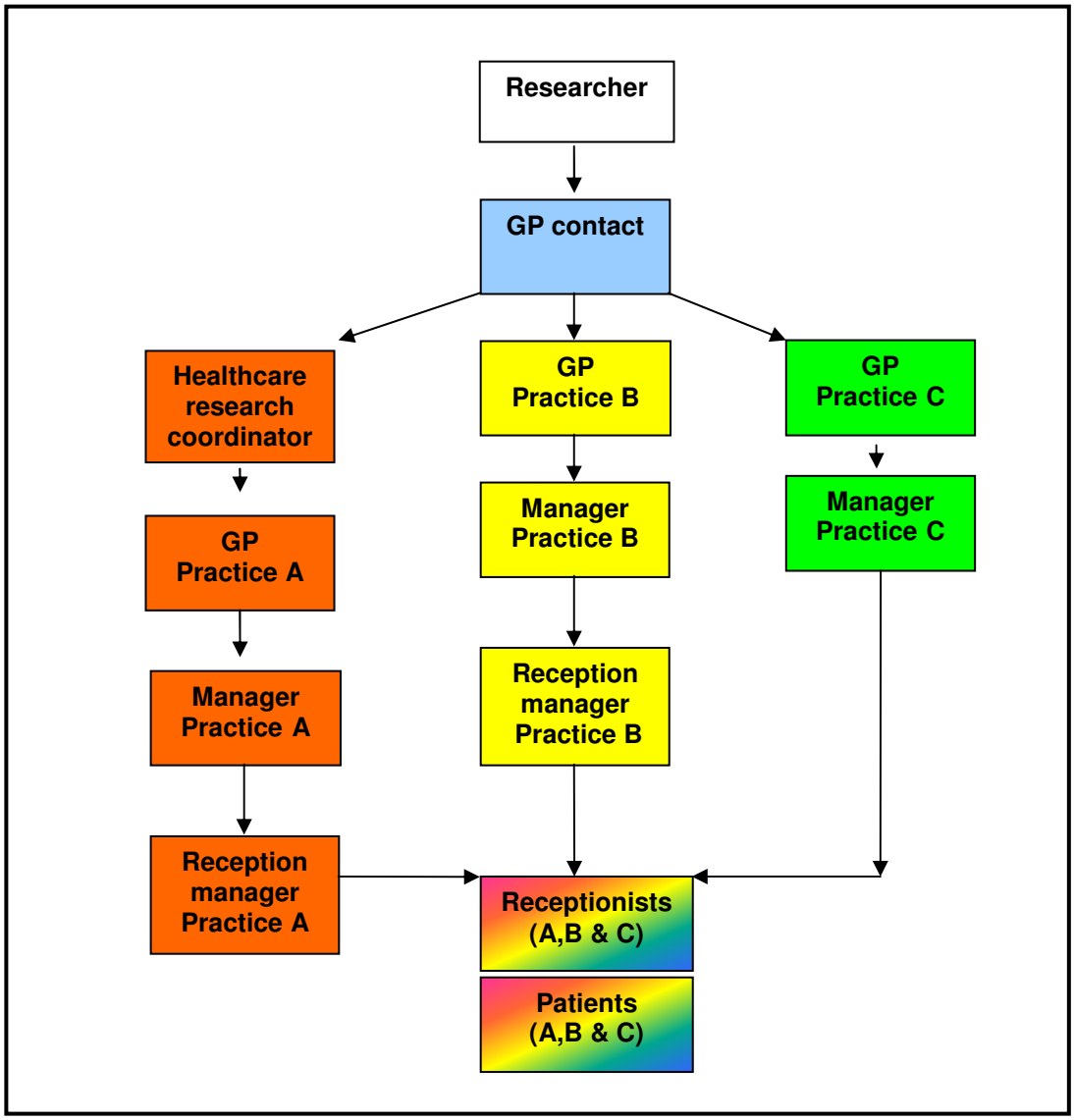
As mentioned in §3.1.1 a range of NHS practices with different social and demographic profiles was required in order to provide a broad-based sample. The three practices where recordings were made were accordingly chosen partly because of their contrasting social profiles but also because they were willing to take part in the research. In addition, one practice which wished to host the research was rejected as unsuitable because it seemed that the practice manager wished to use the findings as a form of staff assessment.

3.3.2 Contact with practices

It was initially thought that practices would be recruited through LPCRN but, before a letter could be sent out to members, Practices A and B, both of which had been identified through a direct chain of personal contacts, agreed to host the research.

Practice C was approached later by a similar direct route, though in a move towards more purposive sampling, insofar as it was thought that the social and demographic profile of the practice would complement those of Practices A and B. The chain of contact for each practice is set out in Figure 3.2.

Figure 3.1: Access route to data



The figure shows that the same GP provided the first stepping-stone to contact with all three practices, though the route to Practice A was a little longer than the route to Practice B, the route to which was in turn slightly longer than the one to Practice C. The period of time which elapsed between the first contact with the practice and the

date of recording also varied from practice to practice: one month at Practice A, five months at practice B and 2 months at Practice C.

In each case there was an initial exchange of emails with the interested GP at the practice but my main contact was always the practice manager. Each manager was sent a letter designed to explain the aim of the research, the research method, and what the research would entail for receptionists (see Appendix 6, p.485 for a sample letter). The response of each practice to this letter was slightly different. The manager at Practice A held a meeting at which the letter was shown to all receptionists, who immediately agreed to participate in the research. The manager at Practice B had more concerns about the proposal, particularly regarding the legality and the feasibility of making recordings from the telephone, since the practice system was part of a Primary Care Trust (henceforth PCT) network which was controlled from a central telecommunication point. A meeting was held at which I explained the research in detail to both practice and reception managers. I then went on to seek an assurance from the Data Protection Officer of Lothian Primary Care Trust that the project was legally sound and to consult the Telecommunications Officer of the PCT on its technical feasibility. Legally it was found to be in order but technically it was thought to be non-viable. The manager at Practice B nevertheless agreed that face-to-face interaction at the front desk could be recorded subject to the unanimous approval of receptionists, which was subsequently given. The manager at Practice C herself took responsibility for committing the practice to taking part in the study on the basis of my explanatory letter. Receptionists were consulted but not shown my letter, an approach with consequences which are described in Chapter 8 (§8.1.1).

3.4. Data collection

In the final version of the research protocol, I outlined the proposed method of data collection as follows:

- A mini-profile will be developed of practice administration, focusing on the work of receptionists and their training.

- A research diary will be kept.
- Informal interviews will be conducted with participating receptionists and, where applicable, the practice manager.
- Numbers will be monitored of those patients who decide to take part in the study and those who decline.
- Subjects will be asked to complete a short, anonymous, questionnaire which will provide information about their age, sex and patterns of attendance at the practice.
- Audio-recordings will be made of receptionist-public interaction, both face-to-face and by telephone. They will be made from a position in which the researcher is unable to hear the interaction between receptionists and patients directly, and is thus unable to hear exchanges involving patients who have not given consent.

Such a schematic description of the process masks the day-to-day actuality of data collection, with its concomitant decisions and difficulties. For me decisions had to be made and problems solved in relation to five areas: style of self-presentation, obtaining access, respect for patient confidentiality, choice of research assistant and technicalities of audio-recording.

3.4.1 Self presentation

In terms of self-presentation, the first decision I had to make was about what to wear when visiting practices. I resolved this by following Clarke's advice, aiming to adopt "… a conventionally tidy or unobtrusively smart standard of dress" (2003: 381). My research assistants followed suit. The second decision on self-presentation concerned how to position myself, both physically and socially. There was no obvious answer to this question but, as far as possible, bearing in mind my overall objective of carrying out research for and with receptionists, I tried to adapt to local practice, joining receptionists in their tea room and taking part when there was lively conversation on more general topics but remaining silent when others did, or when the conversation turned to practice business.

3.4.2 Access

The problem of access was twofold. First there was the question of physical access to practices, which have tight security and are designed to keep out intruders. For example, arriving at the first practice I attended early on a mid-December morning, I found myself in a cold, wet car park before daylight, unable to get in to the practice to set up my equipment before the front doors opened to patients because the back door was also locked and had no bell. This also happened at the second practice, though in better weather conditions. By the time I approached the third practice experience had taught me that it would be better to begin recording just after the front door was opened.

The second problem of access related to when it was appropriate either to ask questions of receptionists which would clarify work practices or simply to engage in rapport-building chit-chat while present at the front desk. At the first practice I began by asking questions during periods when receptionists were not occupied with patients, either directly or on the telephone. However, I quickly realised that receptionists had to use these quiet periods to complete paperwork and other tasks resulting from encounters with patients and, thereafter, remained silent unless spoken to, listing questions to ask when receptionist were off duty. This was made easier by the fact that both practice and reception managers at the first two practices had allocated large amounts of their time to giving me detailed explanations of how reception desks were run and also invited me to seek further information from them whenever I wished. This extensive coverage also proved useful later at the third practice, where only a short explanation of practice procedures was given in advance by the practice manager, although one of the receptionists at the practice volunteered a running commentary on work practices.

3.4.3 Patient confidentiality

A third problem was that of patient confidentiality. I was to be present in the backstage area where patient details which I was not authorised to hear were

sometimes discussed. Practice managers at two of the three practices resolved the potential problem by asking me to sign a form in which I promised to respect patient confidentiality, effectively treating me as an honorary employee of the practice. In addition, the receptionists at all three practices usually lowered their voices or moved away from me when discussing sensitive issues, an extension of their habitual practice of ensuring that their voices were not audible to patients waiting on the other side of the front desk.

3.4.4 Research assistants

Because I was obliged to remain close to front desks while recordings were being made in order to ensure that only consenting patients were recorded, research assistants were needed who would who help me by asking patients for their consent before they reached the reception point. Because they would encounter a wide variety of people from all age groups, both sexes and a whole range of social classes, it was important that the research assistants were accustomed to dealing with people from all walks of life. Potential subjects are also often resistant to a 'cold calling' approach to recruitment to studies or surveys, particularly when sensitive issues may be dealt with, as is the case in healthcare contexts. It was therefore desirable that the research assistants should have sufficient confidence and commitment to approach potential subjects and enough knowledge of the context and purpose of the study to persuade them to participate.

I was fortunate to find two assistants who had both worked as non-executive trustees of Primary Care Trusts and had regularly met both primary care employees and patients in the course of their work. Both were women aged between 55 and 65 with excellent interpersonal skills. One, for whom I used the code IA1, had worked in primary education and the voluntary sector for many years, including with refugees; the other, coded as IA2, had worked to raise awareness of the business world among secondary school students and had also been involved in the rehabilitation of young, homeless people. I was assisted by IA1 at all three practices and by IA2 only at Practice B.

3.4.5 Audio-recording

Overall the difficulties described above were minor ones which did not impinge on the main aims of the study. With the exception of the audio-recording of telephone interaction, the original research method was implemented in full. Recording of face-to-face interaction between receptionists and patients proceeded very smoothly at all three practices. The microphone was always placed next to receptionists' work stations while I controlled the recording equipment and monitored the flow of patients a couple of metres to the side. There are a total of approximately 11 hours of mini-disc recording: 4 hours from Practice A, and just over 3½ hours each from Practices B and C. At each practice all recording was carried out on the same day. In addition to the receptionist-patient interaction, recordings include periods of silence as well as conversations between receptionists and other members of staff or visitors to the practice who are not patients, and comments made by receptionists to the author and the research assistants.

As mentioned above, recording of telephone interaction was less successful. Two attempts were made to record incoming calls for appointments at Practice A but because the equipment which was used was not compatible with the practice's telephone system, it was decided to abandon this aspect of the research. For the reasons outlined in §3.3.2**,** no recordings were made from the telephone at Practice B. It was therefore decided that there would be no recording from the telephone at Practice C either since, in the absence of recordings from Practices A and B, there would have been insufficient data to make analysis viable. The significance of the failure to record any telephone interaction is discussed in §8.1.3.

3.5 Ethnography

As discussed in §3.1.2, it was felt that it would be useful to collect information on the general practice setting to ensure that the verbal interaction would be properly understood. The following section contains a summary of the information about the three practices where recordings were made. It has been collated from a variety of

sources including observation and field notes, a research diary, interviews and the patient questionnaire.

3.5.1 Practices

As Table 3.1 shows, the three practices differ in a number of ways. Practices A and B are both in areas with high levels of social deprivation but differ in both situation and size; Practices B and C are similar in size but have different social profiles; Practices A and C differ in all categories.

Table 3.1: Information about practices

Practice code	Number of GPs	Number of receptionists	Patients per GP*	Socio-demographic profile[17]
A	4	7	1,370	semi-rural, deprived
B	7	8	1,430	inner-city, deprived
C	7	8	1,640	urban, middle-class

* Figures are rounded up or down to the nearest multiple of 10.

Each practice also has a different physical layout. At Practice A the front desk is a long high counter which is partially separated from the waiting area immediately in front of it by a folding screen. The receptionist on duty sits behind this desk facing both patients and a computer screen. Because this practice is paper-free, meaning that the information system in the practice is fully computerised, the receptionist does not have to deal with patient files but she does answer incoming telephone calls for appointments. Each of the practice's receptionists spends one hour each day working at the desk and the rest of the time on other duties, including one area of exclusive personal responsibility. Receptionists are not permitted to move away from the desk when in position there but can speak to colleagues working in two small back rooms, one at each side of the counter, or call for assistance when necessary. Patients await their appointments immediately in front of the reception desk in the small waiting area which consists of chairs grouped in a square with a play area for

[17] Based on information from practices and ISD Scottish Health Statistics (http://www.isdscotland.org)

children in one corner. Colourful information posters and leaflets cover the walls, magazines are scattered on low tables, and patients can often be heard chatting with acquaintances or talking to their children.

At Practice B receptionists work behind a low counter which is separated from the waiting area immediately in front of it by a thick glass security screen. They too have a rotating duty roster but one which works on a day-by-day rather than an hourly basis. The two receptionists on duty at the counter are responsible for drawing and putting away the files for the day's consultations and move freely between the counter and the administrative area behind it. Occasional calls are made from other staff members to the telephone at the front desk but receptionists at the desk do not deal with incoming calls for appointments. The waiting room here is dark and old-fashioned with banks of leather benches both round the walls and in rows across the central area. It is restrained in appearance, with posters neatly displayed in glass cases, but extremely lively in atmosphere, with a popular radio station playing music in the background and noisy interaction between patients, which includes shouting and argument as well as casual conversation.

Practice C has a high narrow front desk with positions for two receptionists behind it. Here too receptionists take shifts at the desk on a day-to-day basis and also have small areas of special responsibility. The practice uses a paper filing system, although receptionists working at the front desk do not draw out files themselves but check them and also take incoming calls for appointments. There are many posters and leaflets in the large entrance area, where there is also space for patients to leave prams or bicycles, but the main waiting area is unadorned by medical information. It is a long narrow room which has a small play area in one corner, is decorated with pot plants and furnished with soft chairs in which patients tend to sit quietly to an accompaniment of slow-tempo classical music.

GPs at all three practices are supported in their clinical work by teams of nurses, therapists and visiting GP registrars or research fellows and in their administrative work by teams of clerical officers supervised by practice managers.

3.5.2 Receptionists

There are 7 receptionists at Practice A, all of whom work part-time and 8 and 9 receptionists at Practices B and C respectively, some part-time and others full-time. At each practice one of the receptionists is also the reception manager. All the receptionists at all three practices consented to be recorded but recordings were only obtained of 16 receptionists, 6 at Practice A (coded RA1 to RA6), 6 at Practice B (coded RB1 to RB6) and 4 at Practice C (coded RC1 to RC4). Two filing clerks who assisted receptionists at Practice A with prescription work during busy spells are also heard on recordings (coded AR1 and AR2). As planned, I obtained information about receptionists and their work in three ways: through semi-structured interviews, which were conducted in the practices before recording began, through observation and note-taking; and through listening to interaction between receptionists which was captured on audio tape. The interview questions, which were not fixed but emerged in the course of informal conversation with receptionists, covered the seven subject areas in the headings below (see Appendix 2, p.455 for details). The discussion reflects my findings from both interviews and observation:

1) Length of service in a practice and amount of experience of reception work.

As might be expected, there were wide variations in length of service and amount of experience with the two oldest receptionists each having spent approaching 30 years in GP reception work and the youngest, who was interviewed but is not heard on the recordings, only 6 months. In addition, some receptionists had come into the work straight from school or college while others had previously worked in different jobs.

b) Type and amount of training and opinions about usefulness of training.

Most receptionists thought that training courses were useful although the amount and type of training undergone by receptionists varied from practice to practice. One receptionist at each practice was a trained medical receptionist. All others had received a week or two of in-house training when taking up employment at a

practice. In addition, all receptionists at Practice B and a few at Practice A had attended one or more supplementary AMSPAR approved training courses (see §1.2). At Practice C no receptionist had had any further, or specialist, training but receptionists reported that a promise had been made that they would be given opportunity to attend courses.

c) Responsibility for making medical decisions.

Receptionists were unanimous in stating that they never made medical decisions, although some conceded after further questioning that, although no patient who required an appointment was ever refused, they did determine which patients should take priority when appointments were allocated and that this process did involve a certain amount of medical judgement. It was also apparent from observation of receptionists at work that they exercised some discretion in the allocation of appointments, for example, by stating to one patient that an emergency appointment was available but suppressing this information when talking to another.

d) Relationships with colleagues in the practice.

Receptionists at Practices A and B reported that relationships with both administrative and clinical staff were good, that the atmosphere in the practice was egalitarian and that all members of staff worked as part of one team. In contrast, several receptionists from Practice C mentioned a hierarchical structure and lack of rapport between doctors and receptionists. All receptionists, however, considered they had developed strong team spirits among themselves. Most of this was borne out by my own observations. In the two more informal professional environments there was joking and banter between receptionists and doctors as well as casual conversation between receptionists during lulls in the pressure of work; in the more controlled, formal, workplace, neither of these types of talk occurred, at least during the period of my observations.

e) Motivation for doing reception work and favourite part of the job.

Almost all receptionists claimed that they were in the job because they wanted to help people and enjoyed working with them. The following individual comments are illustrative of the general feeling among receptionists: 'I like the desk. I like working with people. It can be stressful but I love it.' (RA6); 'Communicating - that's me. I like to do it as best I can - so that would be me helping them get what they want if I can' (RB6). Although some receptionists enjoyed specific features of the job such as filing or processing prescriptions, in line with the main motivation for taking up reception work, most said that their favourite part of the job was dealing directly with patients and being of help to them.

f) Favourite and most difficult aspects of the job.

The least favourite and most difficult parts of the job were not always identical for receptionists. Although dealing with 'difficult' patients was the most common answer to the question about the least favoured part of the job, several receptionists described aspects of the clerical work as their least favoured work while others, at practices where incoming calls for appointments were taken at the front desk, were bothered by the constant ringing of the telephone. However, all were in agreement that dealing with rude or aggressive patients was the most difficult part of the job. It was also the topic which provoked the most colourful set of comments:

'Patients can be two-faced - aggressive with receptionists and nice as pie to doctors.' (RB3)

'Receptionists are 'the hub', 'the first port of call'. They put up with a lot of stick and abuse and everything.' (RB3)

'When you are bending over backwards to help and nothing is good enough, it can get to you.' (RA3)

'I think "I don't get paid to take this." You know what I mean?' (RA2)

'I sometimes feel like saying "Give me the stethoscope and I'll see them".' (RA4)

'I feel like strangling them.' (RA1)

g) Attitudes to patients.

Although receptionists claimed that their intention was to help people, it emerged from my involvement in front desk chat that not all receptionists had an impartial view of patients. Particularly harsh judgement was made of patients who failed to keep appointments while patients who occupied a lot of receptionist time were sometimes classified as 'difficult'. Comment was also made about patients who persistently behaved in a disruptive or drunken fashion and one receptionist declared that she had strong negative feelings about patients who behaved aggressively towards their children.

3.5.3 Patients

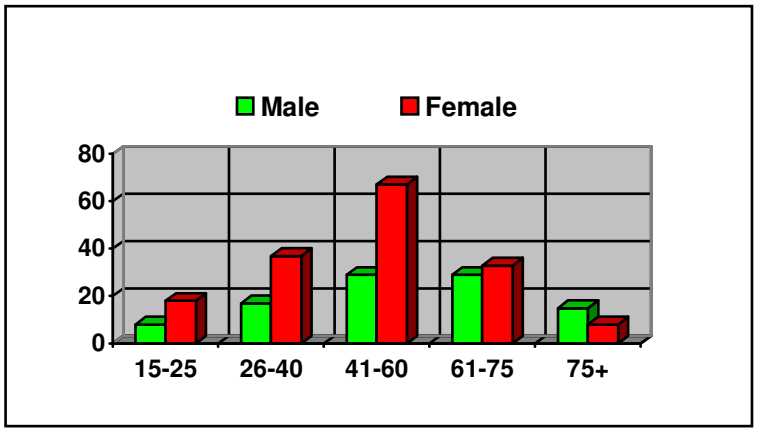
In contrast with receptionists, patients were only informed about the research as they arrived at practices on the day of recording. If they were willing to take part, they were asked to hand in a consent form to a receptionist when they reached the front desk and also to complete the four-point questionnaire which asked for information about age, sex and practice attendance patterns (see Appendix 6, p.484). Although I have no detailed information about those who did, or did not, consent to be recorded, my general impression was that refusal was mainly on the grounds of haste, or from people who were handing in or picking up prescriptions and did not think their participation worthwhile. Details of the consent patterns for patients at the three practices are shown in Table 3.2.

Table 3.2: Consenting patients

Practice	Female	Male	Total	Percentage
A	55	27	82	73%
B	65	46	111	65%
C	57	33	90	70%
TOTAL	177	106	283	69.3%

Although consent rates varied slightly from practice to practice, at all three there was a higher rate for females than for males. This corresponded loosely with the higher attendance rates for females at all practices. Questionnaires were completed by 80% of consenting patients at Practice A, by over 99% at Practice B and by 98% at Practice C. An overview of responses to the questions about age and sex can be seen in Graph 3.1 below.

Graph 3.1: questionnaire completion by age and sex



Age bands are not precisely matched for size but certain trends are nevertheless visible. Females outnumber males in all patient age groups except the over 75s. The largest single group, by a large margin, is of females between the ages of 41 and 60. The numbers for females peak in this age bracket before steadily declining. The numbers for males increase gradually through the first three age bands, remain stable between ages 41 and 70 and then decline. There are very few males or females either in the 15-25 age group or aged 75+. What is not apparent from the graph is that a far larger proportion of males aged between 41 and 60 completed the questionnaire at

Practice B than at the other two practices or that, at Practice C, proportionately more males and females in the youngest age bracket did so. Answers to the questions about practice attendance patterns have not been collated because they were often uncertain. However, they have been used to shed light on the discourse in individual encounters.

3.6 Organisation of data

The data on which my analysis would mainly be based were the 11 hours of audio-recording made at the 3 participating practices. Before the analysis proper could begin, these raw data had to be shaped into a form which made them accessible since, as Edwards observes:

> Recordings are essential tools in discourse research, but are not sufficient by themselves for the systematic examination of interaction. It is simply impossible to hold in mind the transient, highly multidimensional, and often overlapping events of an interaction as they unfold in real time. (2001: 321)

To "reduce the flow of language" (Chafe 2001: 675) to a more manageable form, recordings were first transcribed and then grouped according to their information content.

3.6.1 Transcription

All transcription involves a process of selection and omission which reflects the aims, attitudes and preferences of the transcriber. Ochs and Schieffelin (1979: 44) remark that "transcriptions are the researcher's data" while Gumperz and Berenz (1993: 94) are even more explicit observing that "transcription is an integral part of an overall process of interpretative analysis". It follows that transcriptions cannot be "theory-neutral or without bias" (Edwards 1993: 3). Instead, it is the duty of the transcriber to make explicit the theoretical considerations which have caused specific choices to be made. The broad theoretical aim of my transcriptions is, in the words of Gumperz and Berenz, "to reveal the functioning of communicative signs in the turn-by-turn interpretation of talk" (1993: 119). There is also an underlying practical goal,

namely, to combine faithfulness to the original interaction on which the transcriptions are based with readability and clarity. In other words, as Ehlich puts it:

> … the transcript should be so constructed as to facilitate [the] process of increasing understanding, providing good visualisation of the interaction and the interactional dynamics. (1993: 124)

Underlying these theoretical and practical aims is the overall goal of producing a transcription which is internally consistent and which, adhering to the precepts outlined by Edwards (1993: 5), uses categories which are "*systematically discriminable* in the sense that for every case in the data it is clear for every category whether or not it applies".

The transcription method which I have found best suited to fulfilling the aims stated above is a modified version of the system developed by Jefferson for conversation analysis (Lerner 2004; Maxwell Atkinson and Heritage 1984; Sacks, Schegloff and Jefferson 1974; Schenkein 1978), in which standard orthography is supplemented by additional information about vocal and contextual features which are considered significant. Transcribed features which are regarded as significant in terms of the theoretical goal described above include the mechanisms through which speaker turns are ordered and constructed, marked aspects of intonation, pauses, and non standard usage. The transcription also includes transcriber intervention in the form of coding and contextual information. Extract 3.1 exemplifies most of the transcription practices which are described below and will be referred to in the course of the explanation.

Extract 3.1

(Practice A, Disc 3, Track 3, F/26-40/lm/esm)

1	11-37	PA62:	hiya . I've got an appointment for half <u>past</u> . eh . M M (.) L M
2			(*female names*)
3		RA5:	(10) sorry . what was the name again?
4		PA62:	M M . M . it'll either be M or L
5		RA5:	it's M that's here
6		PA62:	right

7		RA5:	it's with Dr MacLaverty {P62: right} it's in room four . if you just
8			take ‖ a
9		PA62:	‖ can I gie you that?
10		RA5:	oh right . didnae realise you had one as we:ll
11		PA62:	it's room?
12		RA5:	‖ four
13	12-12	PA62:	‖ four? . right . hh hh . right . thank you

i. Speaker turns.

One of the first choices which must be made when transcribing verbal interaction is how to represent speaker turns. I have adopted a vertical layout, rather than columns or partiture, since this seems best to capture the turn by turn, joint, sequential construction of talk by the speakers in the data. Each new speaker turn begins on a new line but is otherwise shown in continuous typeface. Most of the interaction in the data is orderly and dyadic, meaning that there are few cases in which it is difficult to determine who is holding the conversational floor. When there is competition for the floor, it sometimes gives rise to overlapping talk which is marked by double vertical strokes (‖) placed at the point in the turn of each speaker where the overlap begins (e.g. Extract 3.1, lines 7-8). The end of overlapping talk is not marked when one participant subsequently cedes the floor to the other but a new line is used if the speaker who has ceded the turn subsequently regains the floor. Latching, the absence of the standard pause beat between the end of one turn and the beginning of the next one, is another feature which results "from participants' judgements about the content and intent of current speaker's turn" (Gumperz and Berenz 1993: 104). It is represented by single equal signs (=), which are placed both at the end of the turn of the last speaker and the beginning of the turn of the next one. There are also occasions when there are one or two word utterances by a second speaker during pauses between intonation units in first speaker turns, the so-called backchannels or continuers, which Schegloff (1981: 77) describes as "bits of talk […] extracted from what becomes ongoing talk by another". These appear in curly brackets (e.g. {right} in Extract 3.1, line 7) and are distinct from one or two word turns which appear on separate lines (e.g 'right' in Extract 3.1, line 6).

ii. Intonation.

Each speaker turn consists of one or more intonation units[18], prosodic units which, according to Chafe (2001: 675), "provide a useful way of segmenting speech" and "are profitably viewed as expressing constantly changing foci of consciousness". Intonation units, or, in Gumperz and Berenz's terms, "informational phrase[s]" or "rhythmically bounded, prosodically defined chunk[s]" (1993: 95), are separated by time breaks only a fraction of a second long. These are transcribed here as full stops both preceded and followed by single spaces, as is illustrated by line 1 of Extract 3.1: 'hiya . I've got an appointment for half <u>past</u> . eh . M M'. Since intonation is not the main focus of this study, variations in pitch and register within intonation units are only broadly acknowledged in the transcription. The exceptions to this are clearly marked choices, which are measured in relation to a "natural speaking level" which listeners are able to recognise (Couper-Kuhlen 1986; Crystal 1975). Rising intonation is indicated by the use of a question mark (?) and exclamatory intonation by the use of an exclamation mark (!), while marked rising intonation is signalled by a vertical arrow pointing upwards (↑) and marked falling intonation by an arrow pointing downwards (↓). Emphatic stress is shown by underlining (e.g. '<u>past</u>' in Extract 3.1, line 1); prolongation by colons, with each additional colon indicating additional length (e.g. 'we:ll' in Extract 3, line 10), and increase in volume by bold font (**loud**). Non-verbal vocal noises, such as sighs and coughs are described using italicised comments in brackets (*sighs*) and, in another modification of a system devised by Jefferson (1985), [h] is repeated or combined with different vowel symbols to give an idea of the duration and quality of laughter (e.g. 'hh hh' in Extract 3.1, line 13).

iii. Pauses.

Speaker production takes place against a background of silence, which includes cessation of the ongoing talk, varying in duration from fractions of a second to

[18] Intonation units are known by a number of different names. These include tone unit (Crystal and Davy 1969), tone group (Halliday 1985), intonation group (Cruttenden 1986) and breath group (Couper-Kuhlen 1986).

minutes or hours, and serving a whole range of communicative functions (see Jefferson 1989, Tannen and Saville-Troike 1985). In my own data there are mainly silences of short duration which can be characterised as pauses, hesitations or silences, depending on the context and the communicative function which they appear to serve. These include indications of:

- "communicative strain or high rapport" (Edwards 2001: 332);
- "the degree of conversational synchrony in an interaction" (Gumperz and Berenz 1993: 101);
- "additional processes, including those related to planning of utterances and the coordination of turns" (Ehlich 1993: 127);
- "speakers' orientation towards the ongoing conversational interaction" (Du Bois et al 1993: 61).

Their interpretation is context-dependent and they are to be assessed, as Erickson and Schultz (Erickson 1992; Erickson and Schultz 1982) have shown, in relation to the established rhythmic pace of an interaction.

Several forms of pause have been transcribed. Those of less than one second are shown as full stops in parentheses (e.g. (.) in Extract 3.1, line 1.); those of more than one second, with the number of seconds in parentheses (e.g. (10) in Extract 3.1, line 3). When a pause occurs between speaker turns, the co-text is used to determine whether it should be attributed to one or other participant or entered on a separate line with no participant identification. Filled pauses are marked in the transcript in different forms according to their realisation by speakers (e.g. 'eh' in Extract 3.1, line 1). Another type of pause, truncation, occurs when a speaker makes a false start and breaks off abruptly to 'repair' the utterance and take a new direction in the production of a word or phrase. Truncations are identified and measured "not against normative notions of clause completeness but against the speaker's presumed projection for the current intonation unit" (Du Bois et al. 1993: 47). They are marked with a dash placed without spacing immediately after the last word before the truncation, as is shown by 'I-' in Extract 3.2.

Extract 3.2

(Practice A, Disc 1, 39-50, F. No details.)

PA16: hi . I've done a really silly thing . I- . I've run out (.) of my (?name of drug)

iv. Non-standard usage.

Another production feature of potential significance is deviation from standard phonological, lexical and grammatical forms. Many participants in this study speak a vernacular Scottish variety of English, which is exemplified by the boxed items 'gie' and 'didnae' in Extract 3.1. Macaulay (1991) suggests that it is only worth using non-standard spelling where variation has some effect on meaning while Preston (1985; 2000) has shown that the use of 'literary transcription' or 'eye dialect' can "trivialize participants' utterances by conjuring up pejorative stereotypes" (Gumperz and Berenz 1993: 97). It was nevertheless thought important to indicate when Scottish variants of English were used because, as Gumperz and Berenz themselves point out, " [s]tylistic variation […] can reveal significant differences along the formality/informality dimension from which inferences can be made regarding participants' categorization of an interaction" (1993: 97). No attempt has been made to represent features of Scottish pronunciation, such as the dropping of consonantal word endings, the realisation of /t/ as a glottal stop and of /ŋ/ as /n/, since these are so pervasive that standard orthography would have been completely disrupted, but Scottish lexical and grammatical items have been transcribed. 'Gie' in line 9 of Extract 3.1 is a lexical variant of *give* while 'didnae' in line 10 is a grammatical variant of *didn't*. Here too the aim has been to achieve internal consistency so that, as far as possible, the transcript reflects "similar phenomena in similar ways" (Gumperz and Berenz 1993: 99). An attempt has also been made to avoid the transcriptional stereotyping which Jefferson (1996) warns against [19].

[19] Jaffe (2000), Jaffe and Walton (2000) and Macauley (1991) all include useful discussions of the problematic nature of orthographic representation of non-standard forms.

v. Transcriber intervention.

The transcribed text has been annotated in a number of different ways with contextual comments. First, the mini-disc counter time for the start and finish of each episode of interaction has been provided in the left-hand margin. This was done partly for practical reasons, so that episodes could easily be relocated for repeated listening, modification and refinement, but also so that an idea could be obtained of the typical duration of each activity. Secondly, in order to ensure the anonymity of all participants, a system of codes has been adopted, using the letters P for patient, R for receptionist and D for doctor in combination with the letters A, B and C to denote the three practices. The first patient to be recorded at Practice A is thus PA1, the first receptionist RA1, and so forth. In addition, where available, information from the questionnaires is placed at the head of each interaction episode. For instance, the code **M/61-75/lm/esm** indicates that the patient is male, aged between 61 and 75, last attended the practice during the previous month and, on average, attends it every six months.

Personal names are used frequently in the recorded talk. When this happens, they are either reduced to initials or, when a section of text is discussed in detail, represented by pseudonyms, which permit the reader "to get a more vivid impression of who the participants are" (Du Bois et al. 1993: 49). Although care has been taken, as Du Bois advises, to "retain some flavour of the actual names", it should be remembered that this system may produce false impressions. Names "of themselves and in languages such as English, […] have no descriptive content" (Lyons: 1995: 295), but they do index identities through social and cultural associations (see e.g. McConnel-Ginet 2003), which means that there is always a risk of misrepresentation through an inappropriate choice of pseudonym[20]. Finally, clarifying remarks from the transcriber are represented in parentheses using italic script for background information and glosses (e.g (*female names)* in Extract 3.1., lines 1-2) and regular font preceded by a question mark for guesses (e.g (?name of drug) in Extract 3.2).

[20] Receptionists were invited to choose their own pseudonyms but most turned down the opportunity.

There is a complete key to transcription conventions in Appendix 1, pp 313-314.

3.6.2 Categories of interaction

There are five categories of talk involving receptionists in the audio-recordings:

- face to face interaction with patients relating to practice business
- face to face interaction with patients relating to the present research;
- telephone interaction with patients;
- interaction with other members of staff;
- interaction with members of the research team.

The first two of these have been transcribed in full whereas interaction from the latter three groups has been noted but not transcribed in full. This is because it is not directly relevant to the research questions and consequently plays only a tangential part in my analysis. There were also episodes of interaction which occurred during the period when recordings were being made but were not recorded because patients had not given their consent. These are also noted, by means of the code NCP (non-consenting patient).

Interaction with patients relating to practice business

Organisation of the interaction relating to practice business was fairly straightforward since episodes could be grouped into categories according to the front desk activity which was being carried out in them. The only exceptions to this simple rule were episodes in which more than one activity occurred. This was the case, for instance, when a patient who was collecting a prescription also made an appointment. Such instances are treated as separate episodes since one activity was invariably completed before another began.

The most frequent activity at all three practices is checking in for appointments though there is less checking in at Practice A, which has fewer doctors and a smaller

list size than B and C. Patients also sometimes make appointments at the front desk, often after a consultation with a doctor or nurse, but are more likely to do so by telephone. Because the system for dealing with repeat prescriptions is slightly different at each practice, A and B have more prescription collections than C, while only at A is there is a significant number of prescription orders made at the desk. Appointments and prescriptions between them account for the bulk of the interaction in the recordings, including the prescription queries, which outnumber all other queries together [21]. There are also several registrations, two letters are handed in and two collected, a reminder note is organised for a doctor to call a patient, one test sample is handed in and one test result collected and one delivery each is made of flowers and medical documents. There is a comprehensive list of the face-to-face activities in the recordings in Table 3.3.

Table 3.3: Front desk activities

Activity	Practice A	Practice B	Practice C	TOTAL
Check-in for appointment	31	60	58	149
Making appointment	15	14	13	42
Collecting repeat prescription	16	35	13	64
Ordering repeat prescription	14	4	1	19
Prescription query	7	3	2	12
Other query	-	4	3	7
Registration	1	1	2	4
Letters	-	3	1	4
Deliveries	-	-	2	2
Organising a reminder	1	-	-	1
Dealing with test sample	-	-	1	1
Ordering a cab	-	-	1	1
TOTAL	85	124	97	306

[21] Other queries relate to housing assistance forms, a telephone message which has not been passed on, a lost test sample, a long wait for a consultation and a lost bus pass.

Research-centred interaction

Two activities related to the conduct of the research occur in the recordings. These are 'dealing with consent forms' and 'dealing with questionnaires'. In most cases receptionists combine these activities and integrate them into either the opening or closing phase of other business in the manner of Extract 3.3, in which research-related business is dealt with at the beginning of an encounter, and Extract 3.4, in which it is dealt with at the end.

Extract 3.3

(Practice C, Disc 1, 12-49, M/41-60/lw/om)

RC1: hello:

PC8: (.) hi

RC1: thanks . lovely || you can have that (*takes consent form and hands out questionnaire*)

PC8: || right okay . that's good . thanks .

it's er Leslie Black to see Dr Glasgow

(continues)

Extract 3.4

(Practice C, Disc 1, 20-00, M/61-75/ly/o)

RC1: || hello

PC13: || Philpott . Dr Kerr . nine ten

RC1: lovely

(.) and do you have your (2) yes . lovely . can I have

PC13: what do you want? . do you want this bit here? (*consent form*)

RC1: yes . I want . just the consent form {P13: yeah . yeah} and you can have that (*questionnaire*) . thank you very much

PC13: right . thank you

Patients also sometimes question receptionists directly about consent forms, questionnaires and the study as a whole. There will be further comment on the manner in which receptionists accommodate these additional activities and the effect they may have on the discourse in the discussion in §8.1.1).

As mentioned above, the recordings also include three types of interaction which have not been transcribed. These are nevertheless listed below since they shed some light on the front desk experience of receptionists:

- IT1: Telephone calls answered by receptionists at front desk.
- IT2: Interaction between members of practice staff
- IT3: Interaction between receptionists and members of research team.

The incidence of these types of interaction varied considerably from practice to practice, as is shown in Table 3.4.

Table 3.4: Categories of interaction not used in analysis

Practice	IT1	IT2	IT3	TOTAL
A	81	49	54	184
B	12	32	16	60
C	25	30	17	72
TOTAL	118	111	87	316

The table shows that there was considerably more talk which was not face-to-face interaction with patients at Practice A than at either Practice B or Practice C. The variation between practices can be seen even more clearly when the three types of interaction tabled above are subdivided according to their content. Table 3.4 also shows that there was a wide disparity between practices in the amount of telephone use at the front desk. Details are provided in Table 3.5.

Table 3.5: Telephone interaction

Practice	A	B	C
Arranging appointments	38	-	16
Arranging house-calls	4	-	-
Arranging telephone consultation	4	-	-
Arranging ambulance	1	-	-
Checking test results	6	1	-
Checking appointment time	3	-	-

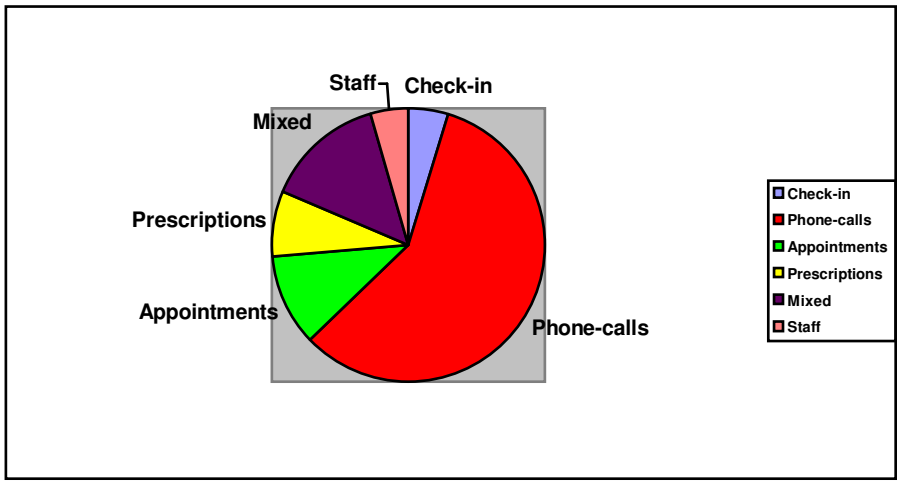
Cancelling appointment	1	1	2
General queries	7	1	-
Calls transferred	7	-	1
Calls re-directed	6	1	-
Messages	4	2	2
Calls to or from doctors	2	-	-
Internal administration	-	6	4
TOTAL	83	12	25

Far more calls were dealt with at the front desk of Practice A, where the telephone rang constantly, even when the call was directed to another line. Telephone talking time at this practice accounted for over half of all talk by receptionists working at the front desk and, at times when appointments were, in the words of practice staff, 'released by the computer' for the following day, for more than half. This is illustrated by the interaction profile of the sixty-four minute recording of RA6 in Table 3.6, which shows the number of encounters in which she was involved, and in Graph 3.2, which shows their duration.

Table 3.6: Encounters involving RA6

Activity	Encounters
Checking in	5
Collection of repeat prescription	6
Order of repeat prescription	2
Making appointment	3
Mixed	4
Working with other staff	8
Telephone calls	32
TOTAL	60

Graph 3.2: Distribution of talking time for RA6



Inevitably, in a context where there were many incoming calls to only one receptionist, both callers and patients at Practice A were often required to wait before they were attended to. The longest wait which I observed lasted for almost ten minutes, though more commonly delays were of three minutes or less. Appointments were also made by telephone at the front desk of Practice C but there was far less pressure on the line and the telephone rang much less often. In complete contrast, the few incoming calls to the telephone at the front desk of Practice B concerned only internal administration and personal messages. Otherwise receptionists made calls out of the practice: to check up on a prescription with a pharmacy, to obtain information about test results from a hospital and to cancel a Chinese patient's appointment because there was no interpreter available at the specified time.

A further category of interaction in the recordings is talk between members of staff. This includes inter-receptionist talk and talk between receptionists and doctors, nurses, a practice manager and clerical officers. As Holmes and Stubbe (2003: 88) observe "[i]t is not generally possible to parcel out meaning into neat packages of referential or transactional meaning on the one hand and social or affective meaning on the other. Talk is inherently multifunctional". However, following a Holmes and Stubbe (ibid.) model, I have been able to distinguish three types of talk between members of staff: on-task talk, in which work issues are dealt with directly, work-

related talk, which is occasioned by the work environment but partly social in nature, and talk which is entirely social.

Table 3.7: Interaction between members of practice staff

Practice	A	B	C
On-task	13	22	27
Work-related	1	6	3
Social	2	4	-
TOTAL	15	32	30

The interaction between members of staff at all three practices was dominated by on-task exchanges, most of them extremely short. Subject matter included prescription issues, patient files, GP diaries and computer problems. It is also worth noting that, contrary to the impression given by the figures in the first row of the table, there was more general cooperation over work issues at Practice B than elsewhere. At Practice C most of the work-centred interaction resulted from one receptionist asking another for help and advice, while at Practice A most of the interaction took the form of questions addressed to the reception manager, who also took a turn at the desk. The work-related talk at Practice A concerned the practical details of buying flowers for a receptionist who had recently suffered a bereavement, while at Practice B it was mainly about a computer course which two receptionists had attended the previous day and at Practice C about a faulty chair which a doctor had attempted to repair. The only substantial period of social talk at a front desk occurred at Practice A where there was a long conversation about the artificial Christmas trees which several receptionists had ordered through a travelling salesman. At Practice B there was some brief general chat about holidays and sunbathing but at Practice C there was no social interaction between receptionists while they were working.

Receptionists also sometimes spoke to members of the research team. As Table 3.8 shows, receptionists at Practice A appeared to be more inclined to engage in this form of talk than those at B and C. This was true both of research-related interaction and conversation of a more general nature.

Table 3.8: Interaction between receptionists and members of research team.

Practice	A	B	C
Research-related	24	12	14
Social	30	4	3
TOTAL	54	16	17

Research-related interaction at all three practices consisted mainly of short exchanges about the procedures to be used when dealing with consent forms and questionnaires and the provision of information about practice procedures. At Practice A there was also a discussion about the positioning of the research assistant, who was recruiting patients to the study and asking for their consent. Social chat ranged from offers of refreshments to the locally embedded topics which, as Schneider (1988) has shown, are typical of talk between speakers who do not know each other well: comments about the weather and other topics arising from the immediate environment, including, on two occasions, comments about the personalities of patients. At Practice A there were also two longer conversations, one about the health of a receptionist with a persistent cough and the other about a recipe for Christmas cake.

3.7 Feedback to practices

When data from a practice had been fully transcribed and analysed, the practice was offered a feedback session which, in each case, was arranged through practice and reception managers and timetabled as part of the reception team's professional development work. The structure of each session was uniform although the detail varied from practice to practice. Each session evolved as follows:

1. Presentation of information about participants in study and the activities which occurred.
2. Introduction to transcription conventions and overview of transcriptions.
3. Awareness-raising activities based on transcriptions.
4. Question and answer session.
5. Feedback.

Attendance at these feedback sessions varied from practice to practice. At Practices A and B all receptionists and part-time receptionists were present throughout the session whereas at C only 3 of 8 receptionists attended. The practice managers of Practices B and C were also both present throughout while the manager at Practice A attended only the first part and left before detailed feedback to receptionists had begun. In addition, sessions were also attended by community receptionists at Practice A, by reception clerical staff at Practice B and, at Practice C, by an interested secretary, who had formerly worked as a receptionist herself. At Practice B, at the practice manager's request, more detailed feedback was provided in the form of a brief report on the research findings (see Appendix 6, p.488). There has also been further contact with practices each time that consent has been sought for data recorded there to be used for a paper or presentation and a follow-up study has been conducted at Practice B, which has become a paper-free practice since the first recordings were made.

3.8 Summary

In this chapter I first discussed the research methodology which was adopted in this study. Points covered include generalisability in qualitative research, the challenges of research carried out in cross-disciplinary contexts and the need for satisfactory research ethics. I went on to provide a detailed account of how the methodology was implemented, describing the route taken to obtaining access to data, the process of data collection, the findings from the ethnographic survey, the transcription and categorisation of interaction on audiotape and the feedback given to practices. In the next chapter I begin to address the first two research questions, in a detailed analysis of the transactional structure of encounters.

Chapter 4

Transactional patterns in front-desk talk

4.0 Introduction

The front desk of a GP surgery in the UK is a known "site of engagement" (Scollon 2001) for the majority of adult citizens. It is an institutional environment which provides a framework for understanding of the talk which occurs there and, as Cicourel (1999: 212) observes of interaction at the front desk of a paediatric clinic, both patients and receptionists "each assume a world known in common and taken for granted" and are pre-aligned in the direction of a specific form of encounter (see §2.2.1). Thus, most patients are aware that, when a receptionist is stationed at the front desk of a National Health Service GP surgery, she is likely to be in a position to offer them the free medical service to which they are entitled while receptionists assume that, when patients approach front desks, they do so with the specific goal of gaining access to some form of medical provision, the legitimacy or urgency of which they will be required to ascertain.

Administrative procedures vary slightly from practice to practice but, at all three front desks where recordings were made, patient actions, such as checking in or making an appointment, and receptionist ones, such as dealing with the ensuing administrative obligations and confirming the identity of patients, are achieved through routinised, though unscripted, episodes of talk, which have a "task-related standard shape" (Drew and Heritage 1992b: 43). As in other goal-directed institutional activity types or genres, each of these encounter types consists of several stages, each of which includes an exchange, or series of exchanges, which is in turn constructed from a sequence of verbal actions. These actions are accomplished through discursive moves consisting of one or more speech acts. Furthermore, as in other service encounters, the language used at the front desk of a GP practice is, typically, formulaic (see §2.3.1).

My aim in this chapter and the next one will be to analyse the discourse patterns through which front desk tasks are accomplished and, in so doing, to answer the first two research questions:

- What are the typical patterns of staging and sequencing in activity types involving medical receptionists and patients? [22]
- What variations are there in the enactment of these patterns?

All discourse is multifunctional and encodes a number of co-occurring patterns (see Jakobson 1960, Halliday 1985). McCarthy (1998: 46) suggests that there are two forces underlying discourse, "the common-sense purposes of interactants and the need to build human relationships". Interactants, that is, simultaneously pursue both transactional and relational goals, each of which generates distinctive patterns (see also §1.1, §2.2.1 and §2.3.1). While it is impossible entirely to separate the transactional and relational functions of discourse, some patterns can be associated with interactants' 'common-sense purposes' and others with their construction of relationships. In this chapter the emphasis is on how discourse patterns are used to accomplish transactional purposes and in the next one (Chapter 5) on how they are used for relationship building.

The chapter is structured as follows: first I outline the normative stages through which front desk activities are enacted and transactional goals pursued and next discuss the typical features of all stages except the opening one, Service Orientation, which, because of its importance in defining the nature of the encounter which is taking place (see e.g. Goffman 1971), will be analysed in detail in the later sections of the chapter. The activities considered are those which are most central in front desk work: checking in (149), collecting a prescription (61), making an appointment (41) ordering a repeat prescription (31) and registration (4).

[22] When the research questions were developed the term 'speech routine' was used to refer to the discourse sequences which I now prefer to call activity types, on the grounds that a speech routine is as likely to be a one word expression as a repeated sequence of turns (Coulmas 1981; Aijmer 1996).

4.1 Overview of transactional patterns

Whatever patients' reasons for engaging in interaction with receptionists, their task goals can be achieved through a small number of transactional stages. There are three types of activity carried out by patients at the front desk: requesting, claiming and reviewing. In appointment making, repeat prescription ordering and registration encounters patients are *requesting* services; in problem-solving ones they are both *requesting* and *reviewing* them; and, when checking in or collecting a prescription, they are *claiming* services which have already been arranged. All activity types have a maximum of four stages: Service Orientation, Information Check, Confirmation and Resolution.

Because of the possibility of non-verbal communication and the use by receptionists of pre-existing documentation, there is not always verbal enactment of all stages. For instance, during the activity of checking in, if the receptionist is already aware of a patient's name and/or sees it written in the appointment schedule, the Service Orientation stage may be silent, while the Information Check may be omitted entirely when patients, as they mostly do, provide all the necessary information as part of the Service Orientation. This is also to a certain extent true of prescription collection, although omission of the Information Check is less frequent, since receptionists are required to confirm the addresses of patients before issuing prescriptions. When appointments are made, all four stages are present while the small amount of talk accompanying unproblematic prescription ordering consists of Service Orientation followed either by Information Check and Resolution or Resolution only.

Each stage is built up through the use of distinctive exchange patterns. As shown in Table 4.1, stages are constructed from two-part exchanges. In the Service Orientation and Resolution stages the receptionist initiates and the patient responds whereas in the Information Check and Confirmation stages either receptionist or patient may initiate.

Table 4.1: Stages with sequences

Stage	Speaker	Action
Service orientation	receptionist	signal availability
	patient	bid for service
Information check	receptionist/patient	seek information
	patient/receptionist	provide/not provide information
Confirmation	receptionist/patient	seek confirmation
	patient/receptionist	confirm/not confirm
Resolution	receptionist	inform/instruct
	patient	accept/reject

For Service Orientation the moves made are signals and bids; for Information Check and Confirmation, requests or elicitations followed respectively by provision or non-provision and confirmation or non-confirmation of the information; and for Resolution, there is informing or instructing about services followed by either acceptance or rejection. There are a few small variations to these patterns. On some occasions the first move of a stage is ignored by the hearer, leading to the omission of the second pair part. Alternatively the reception of the second move can be marked with an acknowledgement token, creating a three-part instead of a two-part exchange.

All encounters begin with Service Orientation, the point at which the agenda is set, and continue with one or more additional stages. The pattern for check-in and prescription collection encounters is shown below, with optional stages in brackets.

Sequence for checking in and prescription collection

Service orientation
(Information check)
(Confirmation)
Resolution

In just over 50% of *check-in* encounters, Service Orientation is followed by Information Check; a further 30% of check-ins have only two stages, Service Orientation and Resolution, while the remainder include one or more Confirmation stages, either before or after the Information Check. During *prescription collection* Information Check follows Service Orientation in well over 75% of encounters; around 15% of prescription collections move straight from Service Orientation to Resolution; and the remainder also include Confirmation stages.

Prescription ordering consists in equal measure of the two sequences: Service Orientation → Information Check → Resolution and Service Orientation → Resolution. Excluding the encounters in which research matters are dealt with after all other business has been transacted, it can be said that all except a handful of these encounters end with a Resolution stage, to give the following characteristic structure:

Sequence for prescription ordering

Service orientation
(Information check)
Resolution

The ordering of stages in *appointment-making* encounters, as well as the whole range of *problem-solving* encounters, is complex, variable and recursive, as is typical in service encounters (see Hasan 1978; Ventola 1987) but it is noticeable that Confirmation is more likely to follow Service Orientation during appointment-making and that there are large numbers of Information Checks in both these encounter types. Both also have an interim Resolution stage, in which a proposed appointment time or problem solution is given and provisionally accepted or rejected. Further information checking and confirmation then typically follows

before the final Resolution stage which, as in checking in and prescription collection and ordering, marks the close of almost all encounters. The typical sequence is thus as follows:

Sequence for appointment-making and problem solving

Service orientation
(Confirmation)
(Information check)
Resolution
Information check
(Confirmation)
Resolution

How all this can work in practice is shown in Table 4.2, in a turn-by-turn analysis of an appointment-making encounter from Practice C (Practice C, Disc 1, 10-41, M/41-60/ly/ey).

Table 4.2: Structure of appointment-making encounter

(R = receptionist RC2; P = patient PC6).

Stage		Action	R/P	Text
Service orientation	1	signal availability	R	morning
	2	bid for service	P	any chance of an appointment for a doctor this morning?
Resolution 1	3	inform	R	not for .
	4	inform		o:h (.) just a moment (.) I've got an app- . a cancellation at nine o'clock=
	5	accept	P	=yeah . I'll take that
	6	inform	R	with Dr Murray Browne

Information check	7	seek information	R	(1) could I ask your date of birth please
	8	provide information	P	oh yes . (er) . one seven fifty-five
	9	seek information	R	(2) and your name is?
	10	provide information	P	it's er . Robin Pae . P A E
Resolution 2	11	instruct	R	(5) alright (.) if you just (4) right . erm . would you like to see the lady over there (*IA1*) first before you see the doctor ‖ thank you
	12	accept	P	‖ yes

In this example, Service Orientation is accomplished through one two-part exchange, each element of which consists of only one speech act - a greeting first and then a question (rows 1-2). It is followed by a Resolution stage (row 3), in which the receptionist begins to inform the patient that his bid is unsuccessful, before interrupting herself and informing him that there is an appointment available (row 4) when she remembers that there has been a cancellation. The informing move, which works as an indirect offer, is achieved through one speech act, 'I've got an app- . a cancellation at nine o'clock' but is preceded by two meta-discursive utterances, the discourse marker 'oh', which marks the change of knowledge state (Heritage 1984b), and the fixed expression 'just a moment', a mitigated form of the imperative 'wait a moment', which holds up the discourse and closes down the preceding topic. The patient's acceptance (row 5) also consists of two separate acts[23], the affirmation 'yeah' and the assertion 'I'll take it', and is followed by an informing move (row 6), in which the receptionist completes the offer.

Next comes the Information Check, which includes two questions, one a conventionally indirect request (row 7) and the other in the form of a statement (row 9), and two answers, the first including two parts, the affirmation 'oh yes' and the

[23] For discussion of the criteria for identifying speech acts see Brazil (1997), Francis and Hunston (1992) and Sinclair and Coulthard (1992).

numerical statement of the date (row 8), and the second a single statement (row 10). After a five second delay, during which the receptionist is using the computer, the closing Resolution stage (rows 11-12) is introduced by the discourse marker 'alright', which marks the end of one discourse stage and the beginning of another. The Resolution stage and the encounter are completed by an instruction from the receptionist which is accepted by the patient.

Although all transactional talk between receptionists and patients is accounted for by the stages described above[24], the ordering and length of the exchanges and sequences, through which the four stages are in turn constructed, is influenced both by participant behaviour and activity type. The typical transactional patterns in all except the opening, Service Orientation, stage of encounters are surveyed in the next section while there is a more detailed examination of the exchanges, moves and acts which together form Service Orientation in §4.3 to §4.6.

4.2 Structure of discourse stages

The three stages to be examined in this section are Information Check, Confirmation and Resolution. In the Information Check stage new information is introduced, while the Confirmation and Resolution stages both complete previous actions, marking transitions and contributing to discourse management. In Confirmation this is achieved by ensuring that information is accurate and in Resolution through proposals for completion of transactional stages.

4.2.1 Information check

The Information Check stage is an essential interactional tool for the accomplishment of service arrangements. Different forms of information checking are required in different encounter types. In the *requesting* and *reviewing* encounter types (appointment making, ordering repeat prescription, problem-solving), checking is used by receptionists to establish patient eligibility or service needs and by patients

[24] Receptionists account for 54% and patients 46% of the talk. It is difficult to say whether these figures are typical or have been affected by the research.

for information about services. During the *claiming* encounter types (checking in, collecting a repeat prescription), receptionist checking of patient eligibility is salient, although there are also service-related checks by patients, for example if they have forgotten the appointment time, the name of the doctor they will be seeing or when their repeat prescription order was handed in.

The types of information which are checked are summarised under three headings in Table 4.3.

Table 4.3: Subject matter of information checks

Information checked	Receptionists	Patients
Eligibility of patient		
Name	X	
Date of birth	X	
Address	X	
Registration status	X	X
Service need		
Name of clinician	X	X
Time of appointment	X	X
Reason for appointment	X	
Reminder card	X	X
Patient requirement	X	
Details of solution	X	X
Service availability		
Availability of appointments		X
Suitability of appointment	X	X
Date of prescription request	X	X
Date of prescription availability		X

There is also variability in the amount of checking which is done and in the length of the Information Check sequence, with more checking in the *requesting* and *reviewing* encounter types and less in the *claiming* ones. During checking in, the number of moves in the Information Check depends on the amount of information provided in the patient's service bid. As already mentioned in §4.1, this stage is

omitted when the patient volunteers the necessary information (own name, appointment time, name of clinician), as shown in the checking in encounter in Extract 4.1, which is presented in tabular form for convenience.

Extract 4.1
(Practice B, Disc 2, Track 1, 02-04, F/41-60/lm/o)

Service orientation	1	RB1:	can I help?
	2	PB54:	eh . got an appointment with em (.) with the nurse {RB1: aha} Elsie Young . quarter to
Resolution	3	RB1:	(2) that's fine

There is also one encounter (Practice B, Disc 1, 24-38, F/41-60/om) in which the single word 'what' is sufficient to prompt the provision of the necessary information whereas, at the other extreme, there are the 8% of patients who, when checking in, provide very little information, omitting their own name, that of the person to be seen and the time of the appointment (see Extract 4.2, row 2). The receptionist supplements this by asking questions (rows 3 and 6).

Extract 4.2
(Practice C, Disc 1, 09-26, F/26-40/lm/esm)

Service orientation	1	RC2:	yes . may I help you
	2	PC5:	yes . I've got an appointment
Information check	3	RC2:	and who's your appointment with?
	4	PC5:	eh . Dr Green
Confirmation	5	RC2:	Dr Green
Information check	6		(18) and your name <u>is</u>?
	7	PC5:	Maria Hierro
Resolution	8	RC2:	that's fine . okay

Although, when prescriptions are collected, more than 50% of patients give their name, the Information Check stage is nevertheless present 80% of the time at Practice A and 92% at Practice C (but only 51% at Practice B), because of the requirement for identity confirmation by means of an address check after the prescription has been located. There is an example of prescription collection in

Extract 4.3, in which the checks are in the form of questions and answers (rows 2-3 and 6-7), in the first case followed by a Confirmation stage involving both the receptionist (RA6) and her assistant (ARA2).

Extract 4.3

(Practice A, Disc 3, Track 3, 54-49, F/26-40/lm/om)

Service orientation	1	PA72: do y'ave a (.) prescription?
Information check 1	2	RA6: and the name?
	3	PA72: Fiona Marr
Confirmation	4	RA6: Fiona Marr
	5	ARA2: Marr?(*AR2 finds prescription*)
Information check 2	6	RA6: (4) and what was your addre:ss?
	7	PA72: 24 Rushton Drive
Resolution	8	RA6: that's you

Similarly, in Extract 4.4, because the receptionist's question is not answered immediately, she prompts the patient by stating his address with question intonation (row 6), thus eliciting a response (row 7).

Extract 4.4

(Practice A, Disc 3, Track 3, 40-57, M//61-75/lm/esm)

Service orientation	1	RA6: hiya (*pause while research forms are dealt with*)
	2	PA68: right . e::h (1) prescription
Information check	3	RA6: (.) and what was your name?
	4	PA68: eh John Haynes
Confirmation	5	RA6: Mr Haynes
Information check	6	(…) your addre:ss Mr Haynes? (.) ‖ 55 Bankhead Drive?
	7	PA68: ‖ oh for here . aye . 55 Bankhead Drive.
Resolution	8	RA6: that's you

If correct procedures had been followed, the receptionist in the last example would not have supplied the address herself but waited for the patient to produce it. There are other occasions when the requirement for an address check is overlooked when a prescription is issued, either because the patient is well-known or again because the

correct procedure is not being followed. In the example in Extract 4.5, the latter seems to be true, since there are no signs of recognition in the discourse and questionnaire information shows that the patient attends the practice infrequently.

Extract 4.5
(Practice C, Disc 2, 38-40, F/61-75/ly/esm)

Service orientation	1	RC1:	can I help you?
	2	PC56:	yes . can I have a repeat . prescription for . C E Naughtie please (*research forms dealt with*)
Resolution	3	RC1:	there you are

On the other hand, there are also times when checks occur where they might not have been expected, either because receptionists have not heard (Extract 4.6, row 3) or because they have not retained (Extract 4.7, rows 1 and 2) information already offered by patients.

Extract 4.6
(Practice C, Disc 1, 25-23, F/41-60/lw/esm)

Service orientation	1	RC2:	|| morning
	2	PC16:	|| Green. Frances Green . I've got an appointment with Dr Williams
Information check	3	RC2:	Dr?
	4	PC16:	Williams (1) nine twenty (*clears throat*)
Resolution	5	RC2:	that's fine .

Extract 4.7
(Practice C, Disc 2, 11-12, No details. F)

Service orientation	1	PC51:	see the nurse at ten thirty . Mary Dawson
Information check	2	RC2:	ten thirty (3) and the name is?
	3	PC51:	Mary Dawson
Resolution	4	RC2:	(7) that's fine

Information Check stages in most checking in and prescription collection encounters are short because a limited amount of information is required. However, appointment-making and problem-solving encounters are characterised by longer, repeated, Information Checks. Checks in appointment-making encounters are also

less formulaic than those in check-in and prescription collection ones[25], although predictable in that they always relate to the availability and suitability of appointments. The question and answer sequences in problem-solving Information Check encounters are non-routine because each problem which is dealt with is slightly different. There is an example of a problem-solving encounter in Extract 4.8.

Extract 4.8
(Practice B, Disc 3, 47-18, F/41-60/lm/om)

Information check 1	1	PB95: how soon can the chemist pick this up?
Information check 2	2	RB6: (.) ‖ you'd like it on Monday?
	3	PB95: ‖ because it's the holiday . aha
Information check 1	4	RB6: we are open on Monday {PB95: right} (.) until twelve of clock . so it would depend if he had sent somedy up
Information check 3	5	which chemist is it?
	6	PB95: it's just the one down the road here
Resolution 1	7	RB6: well . they're normally quite good so if you
Confirmation 1	8	PB95: right (.) so it could be Monday or Tuesday he'll get it
	9	RB6: yeah
	10	PB95: it depends
Information check 4	11	RB6: is that soon enough?
	12	PB95: well she said she's got enough to do her I think until Wednesday
Resolution 2	13	RB6: well that be plenty time
	14	PB95: okay

In this example there are four checks, one in which the patient asks a question about prescription availability (row 1) and three in which the receptionist puts questions which clarify details of the patient's need (rows 2, 5 and 11). There is a step by step movement through these checks until a resolution which is acceptable for both practice and patient is reached and agreed (rows 13-14).

The second Information Check in Extract 4.8 is an insertion sequence, nested in the patient's check and designed to clear the way for the receptionist's response to the

[25] See Appendix 3 for examples of the formulaic language used at different stages of encounters.

question in row 1. As noted in §2.3.2, Zimmerman (1992, 1998) considers that Information Checks, which he terms the "interrogative series", are central for task completion in calls to emergency services, finding that callers only receive answers to their first, service-seeking, adjacency pair parts after lengthy insertion sequences, in which information checking is carried out. We see a related pattern in Extract 4.8, in that the Resolution is only reached after a sequence of information seeking and provision moves. Something similar also occurs when appointment times are negotiated. This is shown in Extract 4.9, which exemplifies the negotiation phase of appointment making.

Extract 4.9

(Practice B, Disc 3 26-00, F, non-native speaker)

Stage		Action	Speaker	Text
Service orientation	1	signal availability	RB4:	yes dear?
	2	bid for service	PB87:	(.) em . please (.) e:h . I want to see the GP:
Confirmation 1	3	request confirmation	RB4:	(.) you want to make an appointment?
	4	confirm	PB87:	if it's possible
Resolution 1	5	inform about service	RB4:	yea:h . w- . next . it'll be next . Thursday or Friday . the first one . or there's . an emergency surgery every morning between nine and ten (1) if it's ‖ urgent
	6	acknowledge	PB87:	‖ okay
	7	inform (contd.)	RB4:	it's
Information check 1	8	elicit information	PB87:	yeah . actually I'm not sick but I have a form for him to jus:t . complete for me . cos I'm a registered teacher . and they gave me a medical form
	9	acknowledge	RB4:	mhm
	10	elicit	PB87:	that the GP should fill
	11	acknowledge	RB4:	mhm
	12	elicit	PB87:	that's what I ‖ have
Information check 2	13	request information	RB4:	‖ you've got your . the GP here?
	14	confirm	PB87:	(.) yeah
Resolution 2	15	inform about service	RB4:	yeah . mhm . so (.) well if it's an emergency we have an emergency service every morning between nine and ten ‖ so you could come in
Information	16	request	PB87:	‖ okay . when you say emergency c- .

check 3		information		is it possible for him to fill the form for me in the mornings?
	17	provide	RB4:	e::r . that's not really what it's for . really oh . you know . you'd need to make an appointment
	18	acknowledge	PB87:	ye::s
	19	provide (cotd.)	RB4:	you know
	20	request information	PB87:	can it be . er . earlier appointment . because=
	21	provide	RB4:	=earliest one I've got's next Thursday
Information check 4	22	request information	PB87:	next Thursday?
	23	provide	RB4:	mhm
Resolution 3	24	inform		(.) I'll just tell you when
Information check 5	25	request information		(.) morning or afternoon?
Information check 6	26	request information	PB87:	what time in the morning?
	27	acknowledge	RB4:	I'll just check and see who I ha:ve
Information check 7	28	request information		(3) e:h . nine thirty? . or later?
	29	confirm	PB87:	mhm
Resolution 4	30	inform (cotd.)	RB4:	and I can give you Dr Rintoul
	31	accept	PB87:	okay

In this encounter, the patient is a newly-registered non-native speaker, with an urgent appointment need which, because it is administrative rather than medical, cannot be treated as an emergency. The receptionist, in her role as gate-keeper, makes two appointment proposals which are conditional upon the patient meeting the necessary requirements (rows 5-7 and 15). These are followed by Information Checks from the patient (rows 8-12 and 16-23) which pave the way for an interim resolution (rows 24-25), followed by further information checking on both sides, until a satisfactory Resolution is reached and the patient accepts the appointment which has been proposed (rows 30-31).

In summary, all these examples of Information Checks demonstrate their importance in front desk encounters. Through them receptionists ensure that patients are correctly linked to services, while patients use them to establish the precise nature of the services which they are organising and claiming. It has also been demonstrated that the number of questions in an Information Check depends on factors such as the activity type, the prior knowledge of the patient, the attention levels of interactants

and whether or not any problems arise. When receptionists are checking the personal details of patients, the wording of the Information Check is formulaic and predictable (see Appendix 3, p.458 for examples of the conversational routines used during Information Check and Resolution stages). When information checking is done in the service of appointment negotiation or problem-solving there are frequent insertion sequences and questioning and answering continues until mutual agreement or understanding is achieved.

4.2.2 Confirmation

Confirmation sequences complement Information Checks in that the same types of information are covered but are distinct from them because they are used to ascertain the correctness of items which have already been mentioned, rather than to obtain new information. Hence, during checking in, the information confirmed is either the name, address or date of birth of the patient or the details of the appointment; during prescription collection, it is the name and address of the patient and, sometimes, the date the prescription was handed in or, from the patient's side, details of when the prescription can be collected; during appointment making, it is likely to be the details of the patient's requirements or the date and time of the appointment; and during problem-solving, it is both patient information and the acceptability of any arrangements which have been agreed.

As some of the preceding examples have shown, Confirmation stages complete preceding actions, marking the transition from one stage to another. They are short and often take the form of repetition of all or part of the information component of the preceding utterance, which may or may not have rising intonation. The latter was the case in the Confirmation stage of Extract 4.4, which is repeated here as Extract 4.10.

Extract 4.10

Information check	1	RA6:	(.) and what was your name?
	2	PA68:	eh John Haynes
Confirmation	3	RA6:	Mr Haynes

The Confirmation in row 3 could be seen as the third part of the exchange initiated in row 1 but I have chosen to analyse it as a separate stage on the grounds that, when receptionists echo or repeat items of information provided by patients, they provide an opportunity for the patient to make a correction if they have misheard or misunderstood. They are thus carrying out an action which is different from the acknowledgement effected by items such as 'okay' or 'fine', which appear as the third element in three-part exchanges. The example in Extract 4.10 also illustrates the reformulation of the preceding utterance which often occurs when confirmation is sought in this way. The change by the receptionist of 'John Haynes' to 'Mr Haynes' suggests that alternative stances are adopted to the information, which reflect the personal and institutional identities of the two speakers (see Sacks and Schegloff 1979). This is a categorisation and positioning device, about which more will be said in Chapter 6.

Confirmation may also have a discourse management function. In Extract 4.9, the receptionist's reformulation, after a short pause, of the patient's 'em . please (.) e:h . I want to see the GP:' to 'you want to make an appointment?' (rows 2 and 3) was, on the surface, a clarification, which was designed to assist a hesitant non-native speaker. However, as Heritage (1985) has shown, formulation is also 'a subtle form of discourse control' which can move an encounter along to the next phase. This was the case in the receptionist's reformulation in Extract 4.9, which incidentally echoes the use of formulation by doctors in consultations (Heritage and Watson 1979; Gafaranga and Britten 2004).

The Confirmation stage then has several functions in front desk talk: it allows participants to establish that the information they have exchanged is accurate; it facilitates transition from one stage of an encounter to another and it provides an occasion for the display of contrasting identities.

4.2.3 Resolution

There are two types of Resolution stage: interim and final. Both are constructed through moves in which receptionists inform or instruct patients but, whereas in Resolution stages at the end of encounters it is recognised that successful claims have been made in patient bids, in interim ones proposals are made to fulfil patient requests. The initiating move of the receptionist is thus likely to be either the statement of an available appointment time or a solution to the patient's problem. The interim Resolution of an appointment need was illustrated in Table 4.3, repeated here as Extract 4.11.

Extract 4.11
(Practice C. Disc 1, 10-41, M/41-60/ly/ey)

Service orientation	1	PC6: any chance of an appointment for a doctor this morning?
Resolution 1	2	RC2: not for .
	3	o:h (.) just a moment (.) I've got an app- . a cancellation at nine o'clock=
	4	PC6: =yeah . I'll take that
	5	RC2: with Dr Murray Browne

The interim Resolution stage may consist of only one brief exchange such as the receptionist's 'well that be plenty time' followed by the patient's 'okay' in Extract 4.8 (rows 13/14) but, when it is staged as part of an appointment negotiation, it can also be more lengthy. This is again illustrated by the example in Extract 4.9, in which the receptionist includes detailed information with the proposed resolution (rows 5 and 15).

When Resolution is final, it comes at the end of an encounter and formulaic expressions are used to indicate that tasks have been successfully completed (see Appendix 3, p.458). These expressions include, from the receptionist, instructions, positive assessments, which are recognised as end-markers or pre-closing bids (see e.g. Linde 1997), and basic information provision and, from the patient, acknowledgements and thanks. These forms are illustrated in Extracts 4.12 (row 4) and 4.13 (row 4).

Extract 4.12
(Practice C, Disc 1, 9-43, M/75+/ly/em)

Service orientation	1	RC1: can I help you
	2	PC12: hello . yes . nine o'clock . Dr Green
Information check	3	RC1: (5) Mr Marshall?
Resolution	4	RC1: just have a seat in the waiting room{PC12: fine } please

Extract 4.13
(Practice A, Disc 1, 27-30, M/26-40/lm/esm).

Information check	1	RA1: what's the ↑name?
	2	PA13: Roy Davies
Confirmation	3	RA1: (3) Roy Davies
Resolution	4	that's fine . that's room seven for you

In Extract 4.13, as well as indicating successful completion with the positive evaluation, 'that's fine', a sign of attention to relational matters (see McCarthy 2003), the receptionist gives the patient explicit information about the doctor's whereabouts, 'that's room seven for you', in a display of institutional competence. The provision of information of this type can be superfluous and a form of face protection (see Chapter 5). However, new patients do need instruction, as shown in Table 4.14, one of the longer Resolution stages in the data. The young, female patient in the example has already been given registration forms but prefers to call at a later date to arrange an appointment for the required health check (row 1).

Extract 4.14
(Practice C, Disc 3, Track 1, 00-52, F/16-25/o/esm)

Confirmation	1	R confirm	RC3:	okay . phone in .
Resolution	2	R instruct 1		but if you could do it before you're ill . we'd like to have that back
	3	P accept 1	PC69:	yep . hh hh . I know
	4	R instruct 2	RC3:	okay . bring . er . if you bring all those things with you when you
	5	P accept 2	PC69:	‖ bring everything when I come
	6	R instruct 3	RC3:	‖ when you've made the appointment with the nurse . it doesn't take long . it's only ten minutes
	7	P accept 3	PC69:	yep . great . okay then . thank you
	8	R acknowledge	RC3:	thanks
	9	P inform	PC69:	bye
	10	R accept	RC3:	bye

The receptionist makes three instructing moves (rows 2, 4 and 6), each of which is accepted by the patient. In fact, like the informing and instructing moves of receptionists in the examples in Extracts 4.12 and 4.13, the responses of patients also manifest relational features. In Extract 4.14 this is seen in both the positive evaluation and polite thanking formula (row 7) and in the use of a goodbye in row 9 (see Clark and Wade French 1981). In one respect this is a transactional move, which also has a discourse management function, since it indirectly informs the hearer that the speaker is about to leave and so end the encounter, but, as Laver (1974) long ago observed, goodbyes are a form of phatic discourse (Malinowski 1923), and tend to be used at boundary points to mark the ritual of transition.

It is often by the presence of non-normative, or deviant, examples that normative patterns are made clear (see §3.1.2). As remarked in §4.1, almost all encounters end with Resolution, making it the most consistently present stage after Service Orientation. There are a few exceptions in which the final Resolution stage in an encounter is followed by Confirmation, as shown in the example in Extract 4.15.

Extract 4.15
(Practice B, Disc 1, 09-30, F/41-60/lm/om)

Resolution	1	RB2: right . unfortunately it's gonna be Dr Ireland you're seeing this morning .
Confirmation	2	is that okay? we had to change the appointments:
	3	PB6: aye ‖ that's fine
	4	RB2: ‖ there was a problem with ‖ Dr Dune's surgery
	5	PB6: ‖ it's just for my tablets
	6	RB2: you don't mind?

The non-standard ending of this encounter seems to be the result of exceptional circumstances. The patient has arrived to find that she cannot see the doctor of her choice and the receptionist must confirm that she will accept the new arrangements. She does so with two checking moves, 'is that okay' and 'you don't mind?', accompanied by two remedial accounts, 'we had to change the appointment', 'there

was a problem with Dr Dune's surgery', in mitigation for the changed arrangements (see Chapter 5 for more detailed discussion of remedial action).

In summary, Resolution stages have four functions. First, they are a response, either conclusive or inconclusive, to service bids; second, they confirm that the transaction is progressing smoothly, indicating that procedurally all is well; third, they work as a form of conversational management, as boundary markers which signal that the discourse stage, or the whole encounter, is nearing completion; and fourth, they have an interpersonal content and contribute to the maintenance of positive relationships.

4.2.4 Summary

Tasks initiated during Service Orientation are completed through Information Check, Confirmation and Resolution stages, which occur in different combinations and frequencies in different activity types. The Information Check, which can be used either to confirm patient details or to take negotiations forwards, consists of sequences of adjacency pairs, which are initiated by both receptionists and patients. Confirmation stages, which perform the important function of ensuring that information is accurate, are also constructed from sequences of adjacency pairs but are more likely to be led by receptionists than patients. There are two forms of Resolution stage. In interim Resolution receptionists inform patients about service options which can either be accepted or rejected; in final Resolution stages, receptionists mark the completion of activities by providing information or instruction, which, if acknowledged by the patient, may lead to a thanking or leave-taking sequence.

4.3 Service orientation

It has been demonstrated that the opening sequence of any interaction both defines the nature of the social encounter which is taking place and indicates the proposed direction of the communication which follows (see e.g. Goffman 1971; Golopenția-Eretescu 1986; Zimmerman 1998). In front desk encounters the first stage is always a

Service Orientation sequence, which begins when patients and receptionists engage in "focused interaction" (Goffman 1963). Except in a few unusual instances, to be described in §4.6, the receptionist's first move, whether explicitly task-focused or more phatic or interactional in style, is always interpreted as a signal that service is available. Ventola (1987) calls this the 'attendance allocation'. It is followed by a statement from the patient of the reason for attendance at the practice, in the move which Ventola (ibid.) terms the 'service bid'.

The first move in the Service Orientation sequence is enacted by receptionists in one of the six ways listed below. (Openings which do not lead to the verbal transaction of business, such as those in which there is only an exchange of greetings or a comment about the research, have been excluded, as have those involving patients returning to the desk for a second time in the course of a surgery.)

1. eye contact;
2. greeting, e.g. 'hi there'.;
3. offer, e.g. 'can I help you';
4. elicitor, e.g. 'are you being served?'; 'yes?';
5. combination, e.g. 'hi there . can I help you?' (greeting + offer);
6. references to research procedures.

Inter-practice variations between these formats are set out in Table 4.4, both as raw figures and as percentages. The figures for openings differ from those for activity types and the total number of consenting patients for several reasons: the opening exchange with some patients was inaudible on some recordings; some patients dealt with more than one matter while at the front desk; and, as mentioned above, encounters with patients who returned to the desk after seeing a member of the medical team have been excluded.

Table 4.4: Overview of receptionist first turns

Action	Practice A		Practice B		Practice C		All practices	
	N	%	N	%	N	%	N	%
Offer	3	**4%**	26	**24%**	18	**22.5%**	47	**18%**
Elicitor	9	**12%**	7	**6.5%**	9	**11%**	25	**9.5%**
Offer + elicitor	-	**-**	1	**1%**	7	**8.5%**	8	**3%**
Greeting + offer	2	**2.5%**	11	**10.5%**	3	**3.5%**	16	**6%**
Greeting +elicitor	2	**2.5%**	-	**-**	-	**-**	2	**0.5%**
Greeting	29	**38%**	41	**38.5%**	18	**22.5%**	88	**33.5%**
Eye contact	25	**33%**	17	**16%**	20	**24.5%**	62	**23.5%**
Research-related	3	**4%**	4	**3.5%**	6	**7.5%**	13	**5%**
Non-standard	3	**4%**	-	**-**	-	**-**	3	**1%**
TOTAL	76		107		81		264	

Note: Percentages are rounded up or down to the nearest 0.5 percentage points

It should first be noted that there is a small group of non-standard opening moves which do not fit neatly into the identified categories, for reasons described in §4.6. There is also some distortion of natural patterns at all practices resulting from the research design which, it will be recalled, involved the handing-in of completed consent forms and the collection of questionnaires. Issues related to the research are referred to in 4% of receptionist first turns at Practice A, 3.5% at Practice B and 7.5% at Practice C. In addition, as will be seen when the first moves of patients are discussed, research issues are also mentioned after many of the non-verbal openings. However, even when research-related openings are discounted, the tables show that there is a great deal of variation in receptionist enactment of the first turn, with a different dominant approach at each practice.

The most commonly used opening at both Practices A and B is the greeting (38% and 38.5% respectively), whereas at Practice C eye contact (24.5%) is favoured slightly more often than greetings and offers (both 22.5%). Far more direct offers of service are made at Practices B (24%) and C (22.5%) than at Practice A, where they are made only 4% of the time. Openings resulting from eye contact (33%) and

elicitors (12%) are slightly more frequent at Practice A than at Practice C, where the figures are respectively 24.5% and 11%, and much more frequent than at Practice B, where only 16% of openings are non-verbal and elicitors are very little used (6%). Overall the most common choice is a greeting (33.5%), which is combined with other forms of opening on an additional 6.5% of occasions. Next come eye-contact based openings at 23.5%, a high percentage which could be a result of the distorting effect of the research process[26], then offers, which are used in 18% of openings overall.

The patient's response to the receptionist's opening move takes one of the forms listed below:

1. eye contact (EC);
2. greeting;
3. service bid;
4. combination (e.g. greeting plus bid);
5. research-related (R-R).

In Table 4.5, these five types of move have been collated with the first moves of receptionists. The first, receptionist, moves are listed vertically and the second, patient, ones horizontally.

[26] The effect of research procedures on the interaction is discussed in greater detail in §8.1.

Table 4.5: First moves of receptionists and patients

PATIENT									
RECEPTIONIST	**Move**	**Bid**	**Greet + Bid**	**Greet + R-R**	**Greet**	**R-R**	**EC**	**N-S**	**Total**
	Offer	32	4	-	2	7	1	1	**47**
	Elicit	13	9	1	1	1	-	-	**25**
	Elicit/offer	8	-	-	-	-	-	-	**8**
	Greet/offer	9	3	-	1	2	1	-	**16**
	Greet/elicit	1	-	-	-	1	-	-	**2**
	Greet	33	30	1	13	8	1	2	**88**
	R-R	5	1	1		6	-	-	**13**
	EC	23	11	5	7	16	-	-	**62**
	N-S	2	1	-	-	-	-	-	**3**
	TOTAL	**126**	**59**	**8**	**24**	**41**	**3**	**3**	**264**

Key: R-R = research-related; EC eye contact; N-S = non-standard practice.

As Table 4.5 shows, patients make service bids after all types of opening move by receptionists, even non-verbal ones and those in which research matters are dealt with. There is also a fairly high level of greeting use by patients (in 91 out of 264 or 34.5% of encounters) and three examples of non-standard practice, which will be discussed in §4.6. The table also reveals more clearly the extent to which the research process disrupted normal procedures, since patients mention research-related matters on 49 out of 264 occasions (18.5%). The overview of patient first turns in Table 4.6 provides a summary of these patterns.

Table 4.6: First moves of patients

Verbal action	N	%
Service bid +/- greeting	185	70.5%
Research-related +/- greeting	49	18.5%
Greeting only	24	9%
Other	6	2%
TOTAL	**264**	

Note: percentages are rounded up or down to the nearest 0.5%

The service bid is made in the patient's first move more than 70% of the time. This figure would undoubtedly have been higher had the research not been taking place. There is evidence for this supposition in the analysis of follow-up moves which shows that, on 48 of the 78 occasions (61.5%) when patients did not use their first moves for service bids, they made the bid at the first available opportunity thereafter, without any further prompting from the receptionist.

It can be seen that any choice made by a receptionist, not only the more explicit references to service, can lead to a service bid from the patient. Indeed, a number of receptionists reported that, in order to avoid interruption when they were working at the front desk on general administrative tasks, they had to refuse all eye contact with patients. This suggests that the opening of a receptionist-patient encounter works in the same way as that of a telephone call (see Schegloff 1986). Simply by virtue of being in position at the front desk, the receptionist is perceived to be ready to provide service. The patient's arrival, which in this interpretation can be regarded as the first move, acts as a summons, in the same way as the ringing tone at the beginning of a telephone call. The receptionist's first utterance is a response to that summons[27]. As in telephone openings, the summonsing party, the patient, makes the reason for the summons/visit the primary topic, since, in conversation analytical terms, it is an accountable action (Sacks 1992).

The preceding overview also reveals that there is a variety of moves used by both receptionists and patients during Service Orientation. The relational implications of these variations will be analysed in detail in the next chapter and their transactional use in the next three sections of this one.

[27] But note that, unlike in telephone calls, where silence in the call receiver's opening move is extremely rare, because speakers at front desks are face-to-face, the receptionist's first move can also be non-verbal.

4.4 Service signals

In this section there will first be detailed description of each of the possible opening verbal moves, all of which are heard most of the time as signals that the patient can make the service bid, and then a short summary of their transactional functions. Neither research-related openings, which are an artefact of the research process, nor 'eye-contact' ones, which cannot be analysed adequately because of the lack of visual evidence, will be included but there will be a sub-section devoted to 'extended sequences', opening sequences, that is, in which the patient's bid is not made immediately after the receptionist's offer.

4.4.1 Greetings

Greetings are the most frequent choice in receptionist openings. Although, they are expressive speech acts (Searle 1969) or acts of phatic communion, which, in the first instance, simply mark recognition of the other party (see Schiffrin 1977), they also serve as "attention-getting devices" (Duranti 1997b), which indicate that focused interaction may begin. This is demonstrated in the examples which follow. In the first of these, Extract 4.16, the patient responds to the receptionist's greeting with a latched service bid, allowing no pause before speaking.

Extract 4.16

(Practice B, Disc 2, Track 1, 03-09, M/61-75/lm/o)

RB3: hi there=

PB27: =can I make an appointment with the nurse please . for a fortnight today please

Because the receptionist's presence behind the desk works as an indicator of availability for service, there is sometimes simultaneous claiming of the floor, as in Extract 4.17, in which receptionist and patient attempt to open the verbal action at the same time.

Extract 4.17

(Practice C, Disc 1, 10-41, M/41-60/ly/ey)

RC6: ‖ hi

PC2: ‖ morning . any chance of an appointment for a doctor this morning?

When a receptionist uses a greeting she explicitly signals her readiness to enter a state of talk, leaving no doubt that the encounter can begin. This is in contrast with simple eye contact, which can lead to confusion, as Extract 4.18 shows.

Extract 4.18

(Practice C, Disc 1, 29-37, F/41-60/lm/esm)

1 PC19: em . Angela Cleary . I've got an appointment with

2 RC2: I'm just . putting a:::

3 PC19: oh right

4 RC2: a patient's (3) yes . and you've . got an appointment?

The patient assumes that a non-verbal opening has been offered and makes the service bid (line 1), obliging the receptionist to provide an account of why service is not immediately available (line 2). The patient's recognition of her mistake is marked by the change of state marker 'oh' (Heritage 1984b) combined with the acknowledgement token 'right' (line 3). It is only after a three second pause (line 4), during which she completes another task, that the receptionist provides an elicitor, so moving to a situation where it is legitimate for the patient to make the service bid. It is to be noted that it is the receptionist who determines when the patient can take a turn, an illustration of the asymmetry in speaking rights between the two groups (see §2.2.3).

Finally, it is also worth noting the absence of 'how are you?' from the list of greeting forms used by receptionists. It seems likely that it is never used for the same reason that it is only present in follow-up doctor-patient consultations (see e.g. Heath 1981; Gafaranga and Britten 2003): because it is likely to be heard not as a greeting substitute (cf. Sacks, 1975) but as a genuine request for information. In these circumstances, as Silverman (1987) demonstrates in his study of a cleft-palate clinic, it may impede patients from proceeding to the service bid.

4.4.2 Offers

An offer is the next most common speech act to occur in openings. Most service offers are made using the standard polite question format *first person modal verb + first person pronoun + 'help' verb + second person pronoun*, giving 'can I help you?' and 'may I help you?'. This style of opening removes any imposition on the patient since both the modality and the use of the first person limit the level of assumption about the patient's needs. In addition, a question forms the first part of an adjacency pair and therefore anticipates a responsive second pair part (Schegloff and Sacks 1973). This makes it an efficient discourse strategy for use in service offers, since it prepares the ground for the service bid even more explicitly than a greeting, directly encoding the receptionist's readiness to 'help' the patient. How this works, in its most simple form, is illustrated by Extract 4.19, in which, in a series of elliptical statements, the patient makes a detailed service bid in immediate response to the offer.

Extract 4.19

(Practice B, Disc 1, 03-18, M/61-75/lw/esm)

RB1: can I help you?

PB2: nurse: eh . nine forty-five . Harry Kewell

Alternative versions of the offer formula are also used. For example, it is modified once to 'can I help someone?' to meet the situational need which arises when a receptionist has been away from the desk and returns to find a group of patients waiting. Not knowing who is at the front of the queue, she makes her service offer more general by using the indefinite pronoun 'someone' (RB2, Practice B, Disc 1, 57-26, F/61-75/lm/esm).

4.4.3 Elicitors

When elicitation is used there is an implicit assumption that the listener already requires something - in this case service - of the speaker. Elicitors take two forms in

these data. Either they are generalised, non-explicit, invitations to speak ('yes?', 'who's next?', 'who's first', 'are you being served there?', 'are you okay there?' and 'okay?'), or they are explicit polar questions, such as 'do you have an appointment?', 'have you got an appointment?' or 'is anybody waiting on a prescription?' (two tokens only) or 'you just handing in?' (one token), which are related directly to one of the services provided by a practice. Both types are framed as questions which, as with direct service offers, await responsive second pair parts.

Generalised elicitors have the same openness as direct service offers. Goffman (1971: 76 footnote) describes 'yes?', the form which occurs most frequently, as the functional equivalent of 'hello'. Its typical effect is shown in Extract 4.20.

Extract 4.20

(Practice A, Disc 2, Track 2, 14-51, F/16-25/lm/esm)

RA3: yes::?

PA38: could I make an appointment please

'Who's next?' and 'who's first?' are more specialised and, like 'can I help someone?', are used when a receptionist arrives at the front desk to find a number people waiting, and is thus obliged to make the offer open to all rather than limited to one interlocutor (e.g. Practice C, Disc 3, 52-55). Each is used only once, despite the frequency with which groups of people are obliged to wait at front desks for service, (suggesting that patients are in the habit of forming orderly queues). In contrast, 'are you being served there?', for which there is again only one token, (Practice B, Disc 1, 72-10, M/41-60/lm/esm), is used when a receptionist arrives at the desk to find one patient waiting and must clarify whether service has been offered. It therefore doubles up as a clarification request.

In closed question elicitors the scope of the question is restricted to the mentioned topic. There are very few examples in receptionist's opening turns. They are present when there is a need to limit the service offer, as in Extract 4.21, in which a filing clerk comes to the assistance of a receptionist at a particularly busy time.

Extract 4.21

(Practice A, Disc 4, 08-28, F. No details)

1 ARA2: is there anybody waiting on a prescription?

2 PA77: no . but have you got a pen? . please

3 ARA2: (2) is there anybody waiting on a prescription?

4 PA79: me . I'm waiting on prescriptions as well hen

Because she is not a trained receptionist, and her remit is only to deal with prescriptions, this speaker is obliged to define her role for patients by using the closed question. Note that the same restricting question is reiterated when the self-selecting patient (Sacks, Schegloff and Jefferson 1974) does not take up the exact service which is offered but instead asks for a pen.

4.4.4 Combinations

Several different combinations of move are found in receptionist openings: greetings with offers (Extract 4.22), elicitors with greetings (Extract 4.23) and elicitors with offers (Extract 4.24).

Extract 4.22

(Practice A, Disc 1, 06-09, F. No details.)

RA1: hi there . can I help you?

PA4: can I have an appointment for today?

Extract 4.23

(Practice A, Disc 3, Track 3, 26-06, F/61-75/lm/om)

RA6: ye:s . hello:

PA64: there's a form first . is that what I've to give you?

Extract 4.24

(Practice C, Disc 1, 16-49, F/16-25/lm/ey. Spanish speaker)

RC2: yes . may I help you?

PC10: (2) er . I have a doctor's appointment now at nine

In each of these examples there is tone unit completion but no pause, which would allow the patient to take the floor, between the first and second moves. All of them can thus be seen as double offers in which different opening styles are combined. This is in contrast with the combined sequences such as the one in Extract 4.25 in which patients have the opportunity to respond to offers but do not take them up.

Extract 4.25

(Practice A, Disc 1, 24-12, F/41-60/lw/ey)

RA1: hi there (.) can I help you? (.) do you have an appointment?

PA12: I have an appointment . aha

In this example both the greeting ('hi there') and the offer ('can I help you'), remain unanswered, despite the noticeable pause after each. Conversation analysts (Sacks et al.: 1974) have found that such a pause in the flow of speech, together with the completion of syntactic and intonation units, signals a Transition Relevance Place (henceforth TRP), a point at which the conversational floor becomes open to new speakers. The TRPs which become available are not taken up by the patient, with the result that the receptionist resumes the floor herself, repeating the service offer by using the more explicit question. The more restricted move, the closed question elicitor 'do you have an appointment?' works as a prompt after an initial offer has been ignored. This style of offer is more likely to be seen in longer opening sequences, when the patient is prevented for some reason from making an immediate service bid. The structure of these extended sequences is described in the next section.

4.4.5 Extended sequences

Extended sequences occur when there is an event at the beginning of an encounter which prevents the patient from making the service bid immediately. The most common such event in the data is the exchange of consent forms and research questionnaires, as in Extract 4.26.

Extract 4.26

(Practice A, Disc 2, Track 2, 01-52, F/16-25/lm/om)

RA2: okay . thank you (1) I'll just swap and give you one of these (*questionnaire for consent form*) (1) lovely . and have you got an appointment?

PA34: aye. Angela Lawrie

Because the patient has handed in the consent form, the receptionist can already assume that she has business to transact, and therefore uses the elicitor as a prompt. There are also a small number of occasions when other actions delay the service opening. In Extract 4.27, for instance, the receptionist uses the closed question elicitor after holding up the service offer herself, in another display of receptionist control of turn-taking rights.

Extract 4.27

(Practice C, Disc 2, 19-09, F/61-75/ly/esm)

RC2: now I'll jus:t be with you in a second . have you got an appointment?

PC52: (.) yes . I do (.) I think it must . it's for a flu injection

The receptionist's opening statement creates a situation which causes the patient to hold back from making the service bid. She subsequently authorises the patient's turn by using the explicit elicitor 'have you got an appointment'. In both of the last two examples, the contrast between the initial, non-service, state and the subsequent availability of service is made more salient by the emphatic stress on the word 'appointment'.

The use of these follow-up elicitors indicates that receptionists are keen to expedite the transactional business. However, when the patient is not seeking the service which is explicitly offered, they can lead to a negative response, as illustrated in Extract 4.28.

Extract 4.28

(Practice A, Disc 1, 50-23, F. No details.)

1 RA1: hi there (1) thank ↑you (*consent form handed in*) ↓thank you

2 PA23: hi:

3 RA1: (.) do you have an appointment?

4 PA23: no I have not

5 RA1: ‖ you haven't got

6 PA23: ‖ it's just for to pick up a prescription for Ronald Christian

A negative response is, in many situations, perceived as the dispreferred option and may necessitate remedial work by participants (see §5.1.3) but in this, as in other negative responses to prompts in the data, the patient moves straight on to the service bid (line 6). The pressure, it seems, to achieve task goals is stronger than the requirement to allow remedy when a discourse misdemeanour has taken place.

4.4.6 Summary

All the styles of opening described above work as signals that service is available, but each has a slightly different discourse function. Greetings are simple signs that the transaction can begin, which eliminate the possible confusion which can arise when no words are spoken by the receptionist and the message is conveyed by the eyes. Conventional polite offers, as well as indicating the receptionist's readiness for interaction, emphasise her service role, at the same time reducing the level of imposition on the patient. Elicitors show recognition that the hearer has a particular need, non-explicit in some formulations but explicit in others. As in polite offers, although the language of elicitation is formulaic, it can be adjusted in response to small changes in the situation. In combination openings receptionists integrate two of these three styles while, in extended sequences, explicit closed question elicitors are used as prompts to signal a return to the service focus, when it has been interrupted by an additional action of some kind.

4.5 Service bids

The service bid is the patient's response to the receptionist's service signal. A wider variety of forms is used in patient bids than in receptionist signals, because patients have a wider range of discourse goals. The style of the service bid depends to a large

extent on the service which is required, but most patients use routine language of some kind. This ranges from the forms, so elliptical that they can be described as telegraphic, used by patients checking in for their appointments (Extract 4.29) to the polite formulas, which are often used when appointments are being made (Extract 4.30).

Extract 4.29

(Practice C, Disc 1, 20-00, M/61-75/ly/o)

RC1: || hello

PC13: || Park . Dr Kerr . nine ten

Extract 4.30

(Practice B, Disc 2, Track 1, 03-09, M/61-75/lm/o)

RB3: hi there=

PB27: =can I make an appointment with the nurse please . for a fortnight today please

There are also some combination moves, parallel to the receptionist ones described in §4.3.4, in which two or more routines are juxtaposed. This is illustrated in Extract 4.31, in which the request routine is prefaced by a greeting, and also includes acknowledgement token/service bid and discourse marker/service bid combinations.

Extract 4.31

(Practice A, Disc 4, 14-26, F/16-25/lm/em)

RA6: yes?

PA80: hiya . can I make an appointment for the midwife please

The exceptions to these simple patterns are the bids in which patients outline a problem. These can be much longer, as Extract 4.32, the most extended service bid in the data, shows:

Extract 4.32

(Practice C, Disc 2, 25-47, F/61-75/lw/esm)

RC2: yes . may I help you

PC55: e:h . yes I think that (.) I'll tell you what happened here . I don't know whether I'm . going daft or not but I was down at Dr Lingfield last week . and I was getting tablets . and he said 'I'll give you a month's supply' you see

RC2: mhm

PC55: and . 'take one a day' . and then . half way through it changed his mind (.) and he said 'ough . I'll give take three times a day' but when I went . today I thought 'my pills have gone down fast' but unfortunately he only gave me twenty eight which is a month if you're taking one but not if you're taking three . ha ha . you know what I mean

RC2: right || so

PC55: || so I wasn't sure if . I've enough . I think . to last over the weekend . just that one I've ticked at the top . but . I wasn't quite su-hh-re what

RC2: and he basically was giving you the prescription for . a month

The occurrence of a problem is a non-routine event which always calls for non-routine presentation as the individual circumstances are explained (see Chapter 7).

As has been shown, there are very few occasions on which a patient's bid is not made immediately after the receptionist's signal that she is ready to provide service. Apart from in research-related openings, patients' service bids are hardly ever delayed except when they return a receptionist's greeting, as in Extract 4.28, copied here for convenience, as Extract 4.33.

Extract 4.33

(Practice A, Disc 1, 50-23, F. No details.)

1 RA1: hi there (1) thank ↑you (*consent form handed in*) ↓thank you

2 PA23: hi:

(.)

3 RA1: do you have an appointment?

In this encounter the patient responds to the receptionist's 'hi there' (line 1) with her own 'hi' (line 2) and, following a noticeable pause, which marks a TRP, is prompted by the receptionist to continue (line 3).

It is even more unusual for a service bid not to follow immediately after a receptionist has provided a follow-up elicitor. I found only one encounter in which this does not happen.

Extract 4.34

(Practice B, Disc 1, 35-28, M/16-25/lw/o)

1 RB2: hi . can I help sir?
2 PB21: yeah . hi . e:m
3 RB2: (.) mhm?
4 PB21: (*laughs*)
5 RB2: have you got an appointment?
6 PB21: yeah . got an appointment for . who's it <u>with</u>? ten past ten with e:r .
7 was that . Hubble?

In Extract 4.34 the patient, amid confirmation and hesitation, mirrors the greeting in the combination opening (lines 1-2) and then falls silent. He laughs in reaction to the receptionist's non-explicit follow-up elicitor (lines 3-4) and still does not produce a service bid. The receptionist then produces a more explicit elicitor (line 5), to which he replies, still hesitantly, with a bid. This type of service bid is so unusual it can be described as non-standard. The exception again proves the rule.

To conclude, the most striking transactional feature of service bids is the promptness with which they are uttered by patients. Although there is interference from the research process, it can be seen that it is very unusual for a patient not to respond to a service signal with a bid. Like the service signals of receptionists, patients' bids are made using formulaic language and, when patients are checking in, this is often extremely elliptical, indicating a high level of situational knowledge. Finally, like variations in the service signal, different formulations of the service bid have relational implications, which will be discussed further in subsequent chapters.

4.6 Non-standard service orientation sequences

Of the 264 openings in the front desk data, only a small percentage does not fit the patterns described above. Although there are exceptions, such as the encounter shown in Extract 4.34, this is usually because of a factor unconnected with the receptionist-patient business. As already mentioned, one such factor enters the situation when research-related matters are dealt with at the beginning of an encounter. In addition, the interaction between receptionists and patients is interrupted several times by sequences in which other events occur. The first of these is shown in Extract 4.35 in which two patients speak to each other after the Service Orientation stage has begun.

Extract 4.35

(Practice B, Disc 2, Track 1, 02-48, F/26-40/lw/o)

1 RB3: can I help?

2 PB44: are you next?

3 PB27: no . you're alright

4 PB44: (1) e:m . I've got an appointment with Dr Ireland at ten to eleven

Merritt (1976) has shown that the discourse structure of service encounter openings becomes more complex when some sort of clarification is needed before the second pair part of the offer-bid adjacency pair is produced. This is usually achieved by means of an insertion sequence, consisting of one or more adjacency pairs placed between the service offer and the service bid. In the encounters between servers and customers which are analysed by Merritt, insertion sequences initiated by the server are frequent at the Service Orientation stage but in Extract 4.35 it is the patient, PB44, who uses the insertion sequence for clarification (lines 2 and 3) before producing his service bid. This non-standard event, of which there is only one instance in the data, both shows how smoothly procedures normally flow and indirectly highlights the lack of need for insertion sequences at the Service Orientation stage of most encounters.

What happens in Extract 4.36 is slightly different. This time the patient is sidetracked first by a friend (line 3) and second by research business (lines 4-5). The doubly abnormal situation results in an atypical service offer, 'and who are you seeing this morning?'.

Extract 4.36

(Practice C, Disc 1, 19-26, F/41-60/y/esm)

1	RC1:	hello: ‖ can I help you
2	PC11:	‖ hi
3		cheers Matt . see you
4	RC1:	(?I'll just take) this one . and I'll give you that (*consent form & quest.*)
5	PC11:	cheers
6	RC1:	and who are you seeing this morning?

The slight deviation from the norm again serves to highlight the conventional and routine nature of most encounters and demonstrates how even a small change in the front desk situation can have an impact on the discourse. This is shown even more clearly in Extract 4.37.

Extract 4.37

(Practice C, Disc 3, Track 2, 41-20, M/61-75/lw/om)

1	RC1:	can I help you? (*phone rings*) that would be my phone in my bag
2	RC3:	hello: . are you here ‖ again?
3	PC79:	‖ I'm going to <u>study</u> the receptionists
4	RC3:	(2) oh you've done that . all that (*consent form*)
5	PC79:	I'm studying you=
6	RC1:	‖ you're studying us
7	RC3:	‖ but you do that every time you come in
8	PC79:	(.) never (.) ‖ hh can I have ←
9	RC3:	‖ well perhaps we study you
10	PC79:	can I have a prescription please?
11	RC3:	for?
12	PC79:	for: . whisky
13	RC1:	for whisky? . ha ha ha

The deviance begins when RC1 turns to answer her mobile phone (line 1) and so switches from a service frame to an interpersonal one (see §2.2.2). The non-institutional frame is taken up by RC3, who takes over from RC1 (line 2) and greets PC79 with a teasing comment 'are you here again?' (line 2). The patient responds to this cue with a tease of his own, 'I'm going to study the receptionists' (line 3), and the theme is sustained by all three participants until the patient, prefacing his request attempt with remedial laughter (Gavioli 1995), which acts as a contextualisation cue (see 2.2.1), returns to the transactional business which has brought him to the surgery ('hh can I have', line 8). This is the beginning of a service bid which is completed in line 10. It is to be noted that RC3, who has taken responsibility for this encounter, immediately cedes the floor and switches to the transactional frame herself (line 11) when the patient turns to business while, when the patient returns to the interpersonal frame with another joke (line 12), it is the non-active receptionist, RC1, who sustains it with him.

This episode of teasing resulted from a combination of unusual events: the mobile phone call, which contravened practice rules, and the research study, which was the first of its kind at the practice. The only other encounters in which there is deviation from standard practice at this point are those in which the research takes precedence. The following example gives a flavour of the comments provoked by the research paperwork.

Extract 4.38

(Practice A, Disc 1, 14-45, M/61-75/lm/om)

PA8: mair rigmarole (*refers to consent form and questionnaire*)
RA1: ha ha ha ha ha ha (1) more paperwork eh?
PA8: || aye
RA1: || ha ha ha ha . thank you
PA8: right darlin' . thank you

Finally there is one instance of the behaviour observed, for example, by Iacobucci (1990) and Jacobs-Huey (1996): interactional language being used to pursue a transactional goal. As in the last two examples, the patient is a man aged between 61 and 75. He has come to the surgery in the hope of obtaining a letter which will

support his bid to be re-housed quickly when his current council accommodation is demolished.

Extract 4.39

(Practice B, Disc 3, 8-14, M/61-75/lw/om)

1 RB6: hi there ‖ John
2 PB81: ‖ ah . you're the one I want
3 RB6: alright?
4 PB81: when you're ready like
5 RB6: I'm ready . what's it for?
6 PB81: are you sure?
7 RB6: ↑yea::h (.) can I take that off you and I'll give you one of these (*consent*
8 *form and questionnaire*)
9 PB81: now like . I've got a wee problem

In a series of moves (lines 2, 4 and 6) which constitute a pre-bid, this patient confirms that the receptionist is both ready and willing to serve him before opening his bid in line 9. It is not uncommon for patients who have come to a practice with a problem to support their bids with accounts, which this patient does indeed go on to provide. The provision of a pre-bid is almost unique and perhaps reflects the patient's view of the degree of imposition in his request.

Although these unusual forms of opening are interesting in themselves, their particular value in the current discussion is in the evidence they provide first, by way of contrast, for the highly predictable development of most encounters and, second, for the way that the discourse reflects the sensitivity of participants to minute changes in the expected situation.

4.7 Conclusions

A number of general observations can be made about the discourse patterns described in this chapter. First, the transactional structure of front desk talk parallels that of service encounters in other settings: examples are the predictable stages (Mitchell 1957), the recursion (Ventola 1987) and the two or three part exchanges

from which each stage is constructed (Merritt 1976). Furthermore, front desk encounters include the frequent checking of personal information which is characteristic of receptionist/client interaction in other institutional settings (Whalen and Zimmerman 1987) and bear some structural similarities to the openings of telephone calls as analysed by Sacks (1992) and Schegloff (1968, 1986). The language of individual moves is frequently formulaic, reflecting the routine nature of the tasks which are being carried out (Kuiper 1996).

The alacrity with which patients make their service bids can also be seen as evidence of two additional feature of front desk talk: the high levels of knowledge of situational requirements and the strong orientation to service goals. Both of these points are illustrated very clearly by the analysis of the Service Orientation stage of encounters. The frequent use of non-explicit service offers by receptionists (over 50% when non-explicit elicitors, greetings and eye contact openings are all included), the extremely high incidence of service bids in response to all types of opening (71%), and the elliptical formulation of both, all suggest that participants are already familiar with the social practices of the front desk. The absence of insertion sequences between service offers and bids, which strongly contrasts with the situation in the commercial service encounters analysed by Merritt, additionally suggests that goals and entitlements are pre-defined. The use of an insertion sequence for clarification by two patients only serves to emphasise this point.

Although there are varying levels of efficiency among both receptionists and patients in accomplishing front desk verbal actions, there is complementarity and reciprocity (see Erickson and Schultz 1982) in their joint completion of administrative procedures. Except when there are problems, tasks are accomplished rapidly through a small amount of discourse and a limited number of discourse stages. These include Information Checks, which can involve extended sequences of orderly, co-ordinated talk, consisting mainly of adjacency pairs; Confirmation sequences which, as well performing the important task function of ensuring that information is accurate, facilitate transition to the next discourse stage; and Resolution sequences, which have several functions: responding to service bids; marking the completion of tasks;

indicating the ending either of encounters or task phases; and providing the interpersonal forms which mark the ritual of passage from a state of talk to the lack of it.

Duranti (1997b) suggests that, because all language use is situated on a formulaic-creative continuum even the most predictable forms are indexed for socio-cultural role, both at the societal level and at the interpersonal one. These points have been persuasively exemplified in studies such as Ji, Kuiper and Shu's (1990) analysis of the changes in formulaic language use after the Cultural Revolution in China and Coupland, Coupland and Robinson's (1992) study of strategic variation in the use of 'how are you?'. As was shown in relation to Service Orientation sequences, despite the tight structure of the discourse and the high incidence of formulaic language, there is ample room for subtle variation in the enactment of individual moves in front desk discourse. The relational implications of these variations will be discussed in Chapter 5.

Chapter 5

Relational patterns in front desk talk

5.0 Introduction

Social actors, according to Goffman (1955, 1971), maintain relationships by collaborating to protect both their own face and that of others and ritual interchanges are used to maintain equilibrium between participants. As already mentioned (§2.2.4), Goffman (1972: 5) defines face as "the positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact". He identifies two types of ritual interchange: the supportive and the remedial. In supportive interchanges ritual equilibrium is maintained through the exchange of verbal offerings whereas in remedial ones interactants negotiate reactions to real or projected offences, "transforming what could be seen as offensive into what can be seen as acceptable" (Goffman 1971: 108). Goffman (1976) saw the exchange of greetings as the most fundamental form of supportive interchange and the sequence remedy, relief, appreciation, minimisation as the most characteristic remedial one but he also pointed out that the two types of ritual are so closely connected that, for example, greetings can be used to provide remedy and requests to provide support (see also Ide 1998). He also acknowledged that there are some circumstances in which face attacks are made and no ritual support or remedy provided (see also Tracy and Tracy 1998; Culpeper 2005)[28].

Goffman suggested that the choice of face-protecting move is determined by factors such as the perceived level of imposition and the relative status and degree of familiarity of speakers, with higher levels of imposition and greater differences in status and familiarity requiring more attention than lower ones. As already mentioned, these ideas were taken up by Brown and Levinson ((1978)1987), who developed both a formula for determining the force of face threatening acts and a

[28] Face attacks, in the form of conspicuously aggressive verbal behaviour by patients towards receptionists, were heard during the research, but none of the patients making them had consented to be recorded.

taxonomy of the linguistic strategies which remedy them. Much of the work in the field of linguistic politeness has been designed to identify the criteria which determine the style or amount of face protection to be expected in different social situations. Goffman's outline of the structure of supportive and remedial interchanges has been greatly elaborated and six inter-related approaches to relationship maintenance through face protection identified. These can be broadly summarised under the following headings:

1. positive politeness - solidarity, rapport and the wish to be part of the group is emphasised;
2. negative politeness - social distance and the wish for personal autonomy are emphasised;
3. conventional politeness - formulae popularly associated with polite behaviour are used;
4. indirectness - Grice's (1975) maxims are violated and inferences are made;
5. avoidance - face-threatening acts are not committed, or commitment to them is reduced;
6. bald on record - the communicative act is realised in the most direct way possible because the threat to face is minimal.

These approaches can be used singly but they may also be combined or used alternately in the course of a single episode of interaction.

While it is recognised, as noted in Chapter 2, that there is no simple correlation either between the action carried out and the level of face threat, or between the discourse move chosen and its remedial effect, analysts continue with their attempts to create predictive frameworks. Spencer-Oatey (2005) suggests that approaches to face protection are affected by three elements: norms and expectations about behaviour; perceptions of the need to protect one's own and others' face; and the interactional needs of the moment. The content of the first of these categories, norms and expectations about behaviour, is affected by the social groups to which speakers belong, their relative status, how well they know each other, the community of

practice, or setting, in which the interaction takes place and the activity type in which speakers are engaged. The second, face sensitivity, reflects both the social and personal identities of participants. The third, the interactional needs of the moment, results from speakers' relational and transactional goals and involves fluctuating levels of imposition, risk and potential face threat.

With regard to this study, although the encounters in the data take place in the same institutional context and involve speakers with a limited set of roles, patterns of face protection are nevertheless affected by a number of differences between sites, activities and participants. First, Practices A and B are situated in socially deprived areas, where the surrounding speech community typically uses local varieties of Scottish English, whereas Practice C is in a middle-class suburb where the prevailing dialect is Standard Scottish English. Second, each GP practice is also a community of practice with its own social and verbal norms: for example, members of staff at Practices A and B, have informal and egalitarian working relationships whereas Practice C is more formal and hierarchical (see §3.5.2). Third, there are variations between the dominant relational styles of individual receptionists and patients. Fourth, different activity types involve different levels of imposition. Fifth, there are different forms of face threat inherent in the roles of receptionists, who provide services, and patients, who require them. Sixth, there are different understandings of the rights and duties created by the institutional context.

I will begin the discussion of face protection at front desks with a reanalysis of the Service Orientation moves which were considered from the perspective of their transactional functions in Chapter 4. I will then go on to examine the forms of remedy provided by receptionists and patients when minor infringements are committed. The analytical method used to identify patterns of face protection consists of comparison of alternative realisations of like actions by different speakers across contexts. Particular attention is paid to fixed ritual forms such as greetings, politeness markers (e.g. 'please', 'sorry') and conventional offers and requests but consideration of these formulaic utterances is situated within the context of a discussion of broader patterns of face protection.

5.1 Service signals

The receptionist's opening move functions as a signal that service is available but it also provides evidence of "the type of participation frame that participants wish to adopt for the interaction" (Goffman 1981: 222). Thus, as well as indicating that transactional work can be done, a receptionist's service signal projects a particular form of server-client relationship. Each of the service signals used (greetings, polite offers and elicitors or a combination of any two) encodes a different approach to face protection. Both greetings and offers have conventional relational implications. Greetings are "access rituals" (Goffman 1971: 79), supportive moves which neutralise the potential threat of moving into a state of communication with another (Ferguson 1976; Goffman 1971) by building rapport, whereas polite offers are remedial and pre-empt virtual threats by showing respect for the hearer's right to autonomy. Elicitors, in contrast, are task-focused and any relational force they have can only be inferred from the context.

When research-related and eye contact openings[29] are excluded and the components of combination openings (see §4.4.4) treated separately, it can be seen that opening moves which clearly index some form of relationship are more common than those which do not. Percentages for the three different forms of verbal signal are shown in Table 5.1.

Table 5.1: Service signals by practice

Move	Practice A	Practice B	Practice C	All
Greeting	68%	61%	37%	56%
Offer	10.5%	45%	50%	37%
Elicitor	23%	9%	30%	18%
Other	6.5%	-	2%	2%

The differences between practices observed in Chapter 4 are even more apparent when the data are presented in this way. Greetings are widely used at both Practices

[29] Because the analysis is based on audio rather than video recordings, I had insufficient evidence to analyse eye contact openings for their interpersonal content.

A (68%) and B (61%), but not at Practice C, where only 37% of verbal openings include greetings. Offers, in contrast, are used in 50% of openings at Practice C and 45% at Practice B but only 10.5% at Practice A while elicitors, the most task-centred option, are little used at Practice B but account for a sizeable percentage of opening moves at both Practices C and A (30% and 23% respectively).

The trends revealed in the table can be associated with the social situation of each practice, as reflected in information gathered through field notes and interviews (see §3.5.1). Both the high incidence at Practice A of supportive, rapport-building, greetings and the correspondingly low incidence of remedial conventional politeness seem to reflect both the practice policy of creating a friendly environment for its patients and its situation in a close-knit, socially-deprived, semi-rural community. At Practice B the mixture of supportive greetings and conventional politeness is a possible consequence both of the practice's stated aim of providing a friendly service and the professional approach shared by all members of staff. The relatively low number of greetings and the predominance of polite offers at Practice C may be the result of the emphasis placed there on efficiency, its situation in a middle-class area and the formality of relationships within the practice. Finally, the presence of higher levels of elicitation at Practices A and C than at Practice B may be the result of the positioning of receptionists, who, at these two practices, were seated behind front desks and working with computers, whereas those at Practice B were standing behind a low counter and making little use of the computer[30].

Although there is some evidence that each practice has a dominant relational style, the receptionists within each practice do not behave in a uniform fashion. Instead, as predicted by the work of Kuiper and Flindall (2000), who used finite state diagrams to track the interactional styles of a group of supermarket check-out operators, each has a preferred routine speech act, or set of speech acts, with which she opens an encounter. The signature styles of receptionists are presented in Table 5.2, which shows, from left to right, the code number of the receptionist, the preferred act type,

[30] I am indebted to Alan Davies for this insight.

the percentage of occasions on which the act is used and the preferred realisation of the act.

Table 5.2: Service signals by receptionist

Code	Act	%	Preferred realisation
RA1	greeting	69.5%	hi there
	eye contact	17.5%	--
	offer	13%	can I help you?
RA2	greeting	57%	morning
	eye contact	43%	--
RA3	eye contact	59%	--
	elicitor	41%	yes?
RA6	greeting	47%	(no clear preference)
	eye contact	26%	--
	elicitor	21%	yes?
	offer	5%	can I help you?
RB1	offer	54%	(can I) help you?
	eye contact	25%	--
	greeting	21%	hi
RB2	greetings	64%	(no clear preference)
	offers	24%	can I help?
	eye contact	12%	--
RB3	offer	53%	can I help?
	greeting	37%	(no clear preference)
	eye contact	10%	--
RB4	elicitor	44%	yes dear?
	greeting	22%	(no clear preference)
	offer	16%	can I help you?
	eye contact	16%	--
RB6	greeting	62%	hi there
	offer	24%	can I help you with something?
	eye contact	14%	--
RC1	offer	49%	can I help you?
	greeting	27%	hello
	eye contact	24%	--
RC2	elicitor	39%	yes?
	offer	23%	may I help you?
	eye contact	22%	--
	greeting	16%	(no clear preference)
RC3	greeting	45%	hello
	eye contact	37%	--
	elicitor	18%	who's next?

All receptionists use a mixture of act types but the preference for a particular format, or realisation of it, is more marked in some receptionists than others. RA1, RB2 and RB6 all use greetings over 60% of the time; RA2 uses greetings, both RB1 and RB3 use offers and RA3 eye contact only over 50% of the time; RA6 and RC3 favour

greetings (47% and 43%), RC1 offers (49%) and RB4 and RC2 elicitors (44% and 39%). In addition to making the service signal with routine choices of act type, many receptionists have a favoured realisation of the act. Thus RA1 and RB6 greet patients most of the time with 'hi there' whereas RC1 and RC3 choose 'hello' and RA6, RB3, RB4 and RC2 always use an assortment of greetings; RC2 makes offers with 'may I help you?' while all other offers are made using variant forms of 'can I help you?'; RA3 and RC2 use the elicitor 'yes?' but RC3 chooses 'who's next?'. Both receptionists' routine usage and digressions from it are analysed in more detail in the next three sections.

5.1.1 Greetings

When receptionists issue the service signal with a greeting, they are using a formula which is common in face-to-face interaction. A greeting is an everyday ritual, a small act of phatic communion, which protects both speaker and hearer by acknowledging that a rite of passage is taking place (see e.g. Firth 1972; Laver 1974). It is accepted that greetings can be individualised to encode social meanings (e.g. Al-Nasser 1993; Dare 1999; Kuiper and Flindall 2000; Schiffrin 1977) and, as Table 5.3 shows, eight different styles of greeting are found in the present data.

Table 5.3: Greeting use by receptionists

Greeting	Practice A	Practice B	Practice C	Total
hi there	16	17	1	34
hello	5	3	19	27
hi	1	18	-	19
morning	6	8	3	17
hiya	4	6	-	10
hello there	1	1	-	2
good morning	-	-	1	1
good morning . hi there	1	-	-	1
Total	34	53	24	111

Each of the greeting forms used by receptionists seems to reflect a particular underlying attitude to face protection. The most frequently used type, 'hi there' (34 tokens), which is used far more at Practices A and B than at the more middle-class

Practice C, connotes an approach designed to be rapport-oriented but non-personal. Lexically 'hi there' is informal, implying social proximity and solidarity but it is pronounced with a chant-like intonation which renders it formulaic (see Ladd 1978) and indicative of a politeness which is regulation rather than tailored to individual patients. It can thus be seen as approximating to the standardised approach to server-customer, or provider-client, relations which Fairclough (1989: 62) calls synthetic personalisation, the "tendency to give the impression of treating each of the people 'handled' *en masse* as an individual" (see also Cameron 2000). Interestingly, the two receptionists (RA1 and RB6) who routinely use this greeting in their opening moves have both had formal training in reception work.

The next highest incidence of tokens is for 'hello' (27), which, like 'hi there' or the similar 'hello there' (2), is also almost always uttered in a routine fashion. 'Hello' also belongs to a more standard language style, which may explain why it is most used by two receptionists at Practice C (RC1 and RC3). Correspondingly, as one would expect, the informal 'hi' (19 tokens) and the even more informal 'hiya' (10 tokens), are both used more often at Practices A and B. All of these greetings indicate a rapport-oriented approach but the remaining greeting types used, 'good morning' in its full (2 tokens) and reduced form, 'morning' (17 tokens), are more formal and associated with social distance, particularly when used in combination with a deference marker or formal title. The two variants of 'good morning' are used by only two of the sixteen receptionists (RA2 and RB2).

As well as having a preferred opening style, most receptionists favour a particular greeting style. As already mentioned, RA1 and RB6 both usually choose 'hi there', RA2 prefers 'morning' and RC1 and RC3 routinely use 'hello'. There is also evidence that some receptionists accommodate (see Giles et al. 1991) their styles to their perception of the patient. One receptionist (RB2) seems to have two routine styles, the formal 'morning' and the informal 'hi', while receptionists RA6, RB3 and RC2 all use four different greeting forms. These individualised forms strongly suggest that, although receptionists use them as attention getters and signals of

availability, their greetings do encode additional information, both about their identities as greeters and their perceived relationships with the greeted.

The adjustment of greeting forms is most marked in the case of RA6, who uses 'hello there' and 'hi there' with patients not known to her, 'hello' as a softener after the elicitor 'yes' and 'hiya' to greet patients whom she already knows. In addition to varying her choice of greeting type, RA6 increases the rapport-orientation of her greetings twice by using direct forms of address, to give the vernacular 'hiya hen' in one case and the more formal 'hello Helen' in the other. There is no personal information about the 'hiya hen' patient, who did not complete a questionnaire, but 'Helen' is a patient aged between 61 and 75 who attends the practice regularly. It seems that a relationship has been established between RA6 and this patient, who is later addressed as 'love', in a display of 'acquaintanceship' (Torras 2005) which defines the encounter as 'one-in-a-series' (Button 1991).

5.1.2 Offers

As already mentioned (§4.3.2), offers are almost always made using variants of the conventional polite formula, 'can I help you?' (92% of offers), in which 'I', the receptionist, seeks permission to give help to 'you', the patient. By using this formula, a receptionist is presenting herself as subservient to the patient, putting her own face at risk while protecting that of the patient, who is given the option of declining (see Leech 1983). The 'can I help you?' offer is a ritualised form, Watts' (2003) expressive politeness, which is institutionalised, predictable and so formulaic that it is almost bleached of semantic content. This may account for the ellipsis by some receptionists of modal + subject ('help you?'), or object ('can I help?'), and, as Blum-Kulka (1987: 131) suggests, makes the format highly rated for politeness partly because, as a formula, it acts as "as a short-circuiting device on the length of inferential processing". Culpeper (1996) also accepts that a great deal of politeness is based on inference and stresses the importance of prosody for the inferencing process. The utterance of the 'can I help you?' offer, using rising intonation with primary stress on the verb help, is also routinised and, particularly in the case of the

reduced form ‘help you?’, results in a stylised, chant-like intonation pattern, similar to the one characteristically used for the ritualised greeting ‘hi there’.

Although offers are almost always made using one or other form of ‘can I help you’, there are a few receptionists who use a different formulation. When receptionist RC2, who has a very formal routine style (see Appendix 3, p.458), makes an offer, she always uses the verb ‘may’, which, because it encodes the modality of permission rather than possibility (‘can’), means there is greater distance and less imposition. On the other hand, RB6, who opens encounters more frequently with a greeting (64% of encounters), routinely uses the longer phrase ‘can I help you with something’ as a prompt after research forms have been exchanged. In this case the face threat to the patient is reduced through the addition of the vague prepositional phrase ‘with something’, which increases the scope of the offer and at the same time provides implicit acknowledgement that, while research forms were being exchanged, a “side play” (Goffman 1969) was in progress and the receptionist was not helping the patient to attain a service goal. Although the offers made by RC2 and RB6 are less common in the data as a whole, they too can be regarded as formulaic, because they are chosen repeatedly by the receptionists in question and articulated with a similar chant-like rhythm to ‘can I help you?’.

There are also occasions when receptionists make less routine choices. In one encounter, with a male patient aged 75+, RC1, for whom the routine choice is ‘can I help you?’, asks ‘may I help you?’ (Practice C, Disc 2, 01-08, M/75+/lm/e3m), perhaps switching to a more formal and respectful style because of the age, or status, of the patient. RB3 also diverges once from her routine choice of ‘can I help?’ producing the more distant, and thus more face protective (see Leech ibid.), ‘could I help’ when making the service offer to a woman aged between 26 and 40 who attends the practice regularly (Practice B, Disc 1, 20-44, F/ 26-40/lm/om). The effect of the increased temporal distance of the past simple verb form is again to reduce the level of imposition but the small amount of information available about the patient makes it impossible to work out why the receptionist makes this change at this time.

There is also one less standard and more explicit offer, “are you okay there? . can I get that one for you?” used by RA1, when she notices a patient who does not seem to know the procedure for posting repeat prescriptions into a box (Practice A, Disc 1, 19-11). Unlike the formulaic offers used in most encounters this one, which combines rapport-building and distance-creating moves, has a ‘recipient design’ (Sacks 1992) matched to the patient. The pre-offer ‘are you okay there?’ and the tag ‘for you’ construct solidarity by showing concern for the patient while the conventional politeness of ‘can I’ sustains the routine deference.

5.1.3 Elicitors

Although elicitors are functionally similar to greetings, they index a different relational approach. There are two forms of elicitor: non-explicit and explicit. Receptionists use four different non-explicit elicitors: ‘yes?’, ‘are you being served there?’, ‘who’s next?’ and ‘who’s first’. The most common of these is the single word ‘yes?’ (86% of tokens) spoken with rising intonation. It is the preferred opening move for RA3, RB4 and RC2, who uses it alone or combined with an offer. It is also used once by RC1, who employs a wide range of opening gambits. ‘Yes?’ is the service signal which has the least relational content, unless it is combined with a rapport-building term of endearment, as it routinely is by RB4, or a polite offer, as it sometimes is by RC2.

Blum-Kulka (ibid.) claims that direct strategies of this type lack concern with face protection. However, as has already been pointed out (§2.2.1), institutional contexts create their own inferential frameworks, which also influence interpretations of attention to face (see also Tracy and Tracy 1998; Holtgraves 2005). As noted in Chapter 4, patients interpret eye contact alone as a signal that the service bid can be made, rendering any talk at the point of opening to some extent superfluous. Given this, it can perhaps be said that all verbal moves in receptionist first turns flout Grice’s (1975) Maxim of Quantity, generating the implicature that a modicum of attention is being shown to the face needs of the patient. Both the service bids which follow it and the absence of any evidence of interactional discomfort in patients (see

below) indicate that 'yes?' is accepted as normal, yet its relational impact is, at best, ambiguous. In one interpretation it might be thought to imply that a polite offer is to follow, but patients might equally easily infer that underlying it is the face-threatening question "what are you doing here?", which is calling them to account.

The next most frequent choices of non-explicit elicitor are 'who's next' (2) and the similar 'who's first?' (1), both again very direct and devoid of overt face-protecting content, although one token of 'who's next' is softened by the formulaic politeness marker 'please'. In addition, both choices presuppose that there is more than one person waiting to be served, and therefore point to the absence of a relational move in the form of an apology for any delay (see §5.3.2). There is also one instance of a direct question about service, 'are you being served there?', which is again mitigated, this time by the deictic adverb 'there', which increases the attention to face by situating the discourse perspective with the patient (see Brown and Levinson 1987).

The second group of elicitors, the explicit ones, are used as prompts when the service bid is delayed (see §4.4.3). The two main forms used are 'have you got an appointment?' (14) and 'do you have an appointment?' (8), with one instance of 'you have an appointment . do you?' and two of 'you've got an appointment?'. Both forms are, like offers, pronounced in a stylised, chant-like manner. There are also four explicit elicitors which refer to prescriptions: 'is there anybody waiting on a prescription?' (2), 'are you up for a prescription?' and 'you just handing one in?'. In the latter two examples the directness of the move is mitigated, the first by the use of a vernacular form ('waiting on')[31] and the second by the shared experience of the context-specific deictic reference ('up for a prescription'). Elsewhere explicit elicitors are softened by the addition of 'with Dr (name)' (1), 'sir' (1) or by use of the patient's title (1), or by temporal reference ('this morning' (1) and 'today' (1)). Several times alternatives are opened up by the addition of 'or' (4); and four times the elicitor is made more informal by the ellipsis of the operator 'have' (2),

[31] There is a more extensive discussion of speech styles in §6.2.

As mentioned in the previous chapter, even when softened, explicit elicitors are very direct and create the potential for relational discomfort. Because they create pressure to provide a specific reply, which could be interpreted as a dispreferred negative action (see Levinson 1983, Pomerantz 1984), they are potentially threatening to the face of both receptionist and patient. It is therefore surprising first that so many explicit elicitors are used (12 at Practice A, 10 at B and 7 at C[32]) and, second, that on nine of the ten occasions when they are followed by a negative response, there is no increase in the incidence of the false starts, double takes, nervous gestures, stammers, hesitation markers and uncomfortable pauses which, according to Erickson and Schultz (1982: 113) reveal some form of arrhythmia and are therefore signs of "interactional discomfort and negative affect". Instead, each negative response is a straight 'no', followed eight times out of ten by a statement of the actual reason for attendance. This is illustrated in Extract 5.1. Both the declarative shape of the elicitor and the tag which is appended make the receptionist's question appear coercive (see Woodbury 1984). The patient counters this with a firm reply.

Extract 5.1

(Practice C, Disc 3, Track 1, 03-04, M41-60/lm/om)

RC3: that's for <u>you</u> (*gives patient questionnaire*) . and you have an appointment . do you?

PC70: no . I want to make one

Even when discomfort is shown by the patient, it is not very marked, as shown in Extract 5.2 (line 5).

Extract 5.2

(Practice C, Disc 3, Track 2, 03-54, F/61-75/lw/om)

1 RC3: hello

2 PC71: hello: (*consent form is handed in*)

3 RC3: that's what you need (.) for that (*questionnaire*) . have you got an

4 appointment? . or

5 PC71: no . I . it's a pr- prescription I'm picking up

[32] As mentioned in Chapter 4, the high incidence of explicit elicitors may be an artefact of the research.

The patient giving a negative response in Extract 5.2 makes two false starts ('I' and 'pr-' in line 5) while explaining her reason for coming to the practice yet the patient in Extract 5.3, who responds positively to the receptionist's elicitation question, pauses twice as well as making a false start, suggesting that, although her response is positive, she is experiencing slightly greater discomfort.

Extract 5.3

(Practice C, Disc 2, 19-09, F/61-75/ly/esm)

RC2: now I'll jus:t be with you in a second . have you got an appointment?

PC52: (.) yes . I do (.) I think it must . it's for a flu injection

Holtgraves (2005: 81) points out that "if a speaker's politeness level is a function of his or her perception of the social situation, then observers can determine the speaker's view of that interpersonal situation". The levels of use of explicit elicitors, the absence of accounts or apologies from receptionists when patient replies are negative and the absence of dispreferred-action turn shapes in ninety per cent of negative responses all suggest that they are not considered inappropriate or impolite in the context. There are only two encounters, illustrated above in Extracts 5.2 and 5.3, in which patients do show signs of interactional discomfort in their replies to explicit elicitors, one after a negative and the other after an affirmative reply. If Holtgrave's view is accepted, one can conclude that these patients, both of them women aged between 61 and 75, are displaying higher levels of face sensitivity than is the norm for this environment.

Although a 'bald on record' approach (Brown and Levinson ibid.) seems acceptable to patients as well as receptionists, it is not inevitable and more face-sensitive options exist. This is demonstrated by the two instances in the data, both from Practice B, where follow-up prompts are made using offers, after patients have used their first available moves to deal with research matters. In one of these the receptionist, RB2, asks 'what can I do for you?' (Practice B, Disc 2, Track 1, 32-43, M/41-60/lw/o) and in the other the receptionist, RB6, asks 'what can I help you with?' (Practice B, Disc 3, 67-53, F/26-40/today/when sick). These prompting offers are more explicit than

the ‘can I help you’ type, since they include the interrogative object pronoun ‘what’, but they are far less direct than the polar questions which are more regularly used to prompt bids.

5.1.4 Combinations

As shown in Chapter 4 (§4.4.3), there are occasions on which receptionists use composite opening moves, whether combining a greeting with an offer (16), a greeting with an elicitor (2) or an elicitor with an offer (8). Combination service signals show that, as well as developing routine approaches to face protection, receptionists construct their relational positions online and in direct response to their perception of patients. When receptionist RA1 follows a greeting with an offer (‘hi there . can I help you?’, Practice A, Disc1, 6-09, F), as well as defining the signal more clearly, she projects a combination of friendliness and deference, whereas when receptionist RA3 follows an elicitor with a greeting (‘ye:s . hello:’, Practice A, Disc 3, 26-06, F/61-75/lm/om) one has an impression, reinforced by the lengthening of syllables in both elicitor and greeting, that an initially impersonal style has been remedied as the patient, who attends the practice monthly, is recognised. When receptionist RC2 follows an elicitor with an offer (‘yes . may I help you?’, Practice C, Disc 1, 16-49, F/16-25/lm/ey), it seems that she is correcting the direct approach (‘yes’) at first taken to a young patient by adding the polite offer (perhaps because of her awareness that a recording is being made[33]). In all these cases relational considerations appear to have stimulated the double signals, in contrast with the signals first shown in Extract 4.25, (‘hi there (.) can I help you? (.) do you have an appointment?’, Practice A, Disc 1, 24-12, F/41-60/lw/ey) in which transactional concerns are to the fore.

5.1.5 Summary

The majority of receptionists make service signals using simple rituals of relationship maintenance. The dominant style of face protection varies by practice and by

[33] This receptionist appeared nervous, which may have been in reaction to the research (see also §8.1.1)

individual, with some tending towards the use of supportive, rapport-building greetings, others towards social distance and the use of conventional polite forms. Furthermore, although the service signals of most receptionists have become streamlined, routinised and formulaic by months, or years, of repetition, receptionists, while remaining focused on task goals, also sometimes personalise these forms, thereby accommodating to patients and adjusting to situations through small variations in stylistic choice.

5.2 Service bids

The patient's service bid is made in response to the receptionist's service signal. The majority of patients use the bid either to make or check in for an appointment, or to order or collect a repeat prescription[34]. The four activities correspond to four stages in a cycle. When patients ask for appointments, they have symptoms of illnesses which they wish to have treated. They check in to see GPs, who attend to the symptoms and often provide them with prescriptions. These in turn entitle them to obtain medicines, which (they hope/anticipate) will remove or alleviate their symptoms. Through the ordering and collection of repeat prescriptions, patients achieve ongoing accomplishment of treatment by the replenishment of drug supplies.

Of these four activities, making an appointment seems likely to represent the greatest face threat for patients, since it is a bid for access to the whole therapeutic process, without which none of the subsequent activities can be performed. In contrast, when checking in, patients are claiming appointments which have already been given, just as when collecting repeat prescriptions they are claiming entitlements which have already been granted. There is however a difference between checking-in and prescription-related activities, since checking-in is for a service which is provided by a GP whereas repeat prescription processing is carried out by receptionists. Patients have four different approaches when making their service bids:

[34] Patients' bids to have problems solved have a more elaborate discourse structure, which will be analysed separately in Chapter 7.

1. make the bid without using any face protecting moves;
2. present the bid as an obligation or need (e.g. 'I've got to', 'I've to', I need to);
3. mitigate the bid (e.g. 'just', humour);
4. use formulaic politeness (e.g. 'please', 'can I', 'I was wondering if').

Although patients have the right to treatment and are in an institutional context which might be expected to "mitigate[s] the dispreference for launching requests seen in everyday conduct" (Vinkhuyzen and Szymanski 2005: 91), it seems that they do treat service bids as matters for remedy. However, as Table 5.4 shows, the four approaches listed above are used in different proportions in the bids for different services, suggesting that patients perceive different levels of face threat and imposition in the four activity types for, as Lindström (2005) notes, the syntactic forms of requesting styles reveal attitudes to entitlements.

Table 5.4: Patterns of remedy by activity type

Approach	Zero	Obligation/need	Mitigation	Formula
Check-in	99%	-	-	1%
Prescription request	18%	-	64%	18%
Prescription collection	28%	21%	12%	39%
Appointment request	16%	6%	6%	72%

Service bids for the claiming activity type of checking-in show the least attention to face concerns, with 99% of bids made without obvious remedial action, while those for the arranging activity of requesting an appointment show the most, with some form of face protection used in all but 16% of encounters. For prescriptions, there is again a little less face work done in the claiming activity of collection than in the arranging one of requesting, although patients collecting prescriptions make far fewer unprotected bids (28%) than patients checking-in, while those requesting prescriptions do less face work than those who are arranging appointments. As shown in Table 5.5, patterns also vary slightly according to practice.

Table 5.5: Patterns of remedy by practice

Practice	Zero	Obligation	Mitigation	Formula
A	34.5%	10%	16.5%	40%
B	-	18%	18%	64%
C	17%	12.5%	8%	62.5%

The differences are not great, and are affected by the frequencies for different activity types at the three practices, but there is less use of remedy, particularly conventional formulaic politeness, at Practice A than at either B or C, a slightly higher use of the obligation/need approach at Practice B, where some form of remedy is provided by all patients, and a low incidence of mitigating moves at Practice C. These differences will be accounted for in the discussion which follows.

5.2.1 Checking-in

With the exception of two patients who added the polite request marker 'please', all patients (N141) checked in for appointments either by making a 'statement of presence'[35] or by prefacing a factual statement with a verb of possession. Each of these approaches was accomplished through a restricted number of forms, all of which are represented in Table 5.6.

Table 5.6 Check-in bids

<table>
<tr><td rowspan="3">1</td><td colspan="3"></td><td rowspan="3">Dr X
the nurse</td><td rowspan="3">(time)</td><td>(name)</td></tr>
<tr><td colspan="2">(it's) name</td><td rowspan="2">to see
for</td><td></td></tr>
<tr><td colspan="2">I'm here</td></tr>
<tr><td>2</td><td>I've got
got
I have
I've</td><td>an
appointment</td><td>with</td><td>(name)</td></tr>
</table>

[35] Thanks to Hugh Trappes-Lomax for this terminology.

In the presence style (1), appointment details are given either alone or prefaced by 'I'm here' or 'it's + name' and in the possession style (2) appointment details are preceded by one of two verbs, 'have' and 'have got'. The possession style is more common than the presence one, although there are again differences between the three practices, as shown in Table 5.7

Table 5.7: Check-in styles

	Practice A	Practice B	Practice C
Presence	20%	38%	50%
Possession	80%	62%	50%

The marked difference between practices may be a reflection of the availability of appointments, since the possession style was most used at Practice A, where appointments seemed to be in the shortest supply. Although this opinion is not substantiated by any figures, it appeared to me that patients had to work harder and wait longer for their appointments at Practice A. Almost half the patients who applied for appointments at the desk were asked to call again later whereas appointments were always given at B and C, unless patients asked for dates and times well into the future[36]. Because of these difficulties, patients at Practice A were perhaps more inclined to regard appointments as hard-won possessions.

Most patients provided receptionists with one or more of the three possible items of necessary information (person to be seen, time of appointment, own name) but, as Table 5.8 shows, patients were far more likely to give the appointment time or the name of the person they were seeing than to state their own names. This suggests that patients make the assumption that their names are already known.

[36] One of the reasons for this disparity may have been the open surgeries, held every morning at both Practices B and C, which allowed patients to get appointments at very short notice.

Table 5.8: Content of information provided

	Practice A	Practice B	Practice C	TOTAL
Person seen	13	37	31	81
Time	16	50	35	101
Own name	9	13	19	41

The quantity as well as the content of the information provided varied by practice, as demonstrated in Table 5.9.

Table 5.9: Quantity of information provided

	Practice A	Practice B	Practice C
No information	7%	-	9%
1 or 2 items	90%	90%	74%
3 items	3%	10%	17%

Patients at Practice B provided the most information overall, while patients at Practice C were the most likely to provide all three items of information and those at Practice A the least likely to do so.

The presentation of the information components of the bid also varied. Some of the time patients used complete clauses but, equally often, bids were elliptical with either subject only or subject and verb omitted. Elliptical styles accounted for approximately 18% of check-in bids at Practice A, 26% at Practice B and 27% at Practice C and consisted of combinations such as those shown in Table 5.10.

Table 5.10: Style of information provision

1	*name* for *clinician*	Ruby Service for Dr Brown
2	*clinician* for *time*	Dr Mertoun for nine-forty
3	*clinician + time*	Dr Glasgow . nine twenty
4	*clinician + name:*	Dr Mertoun . Peter Giggs
5	*name + clinician*	Moira Rathmel . Dr MacLaverty

Unless it is accompanied by a politeness marker such as 'please' or anticipatory 'thanks', the information provision which constitutes the check-in bid may at first appear neutral with respect to face. However, as already suggested in §5.1.3, face protection must be interpreted in relation to the context. Patients provide different amounts of information with, at one end of the scale, the bare minimum and, at the other, the full range of required details. Seen from one perspective, patients who give all the relevant information are respecting the face of receptionists by providing maximum cooperation; seen from another, they are protecting their own self-images by fully accounting for their presence. High level information providers also boost their self-images by presenting themselves as competent users of the service whereas low level providers risk appearing incompetent.

Like receptionists, patients also tend either towards positive, rapport-oriented, or negative, distance-oriented politeness in their personal styles. The patient in Extract 5.4 has a rapport-oriented style: she uses the informal greeting 'hi', makes the bid more casual by omitting both the subject and the operator, omits the doctor's title, uses the preposition 'for' rather than the more formal 'to see', and uses an affiliative high rising tone at the end.

Extract 5.4

(Practice B, Disc 3, 7-14, F/41-60/lw/om)

PB90: hi . got an appointment for: Robin Ritchie at twenty to ↑two

In contrast, the patient in Extract 5.5 has a socially distant style. She makes a formal statement, using the full verb form 'I have', rather than the reduced conversational 'I've' or the more informal 'I've got', accords the doctor his full title and also spells out the time.

Extract 5.5

(Practice B, Disc 3, 00-55, F/61-75/lw/om)

PB73: I have an appointment with Dr Dune at two o'clock

The examples are both from Practice B but both styles are represented at all practices.

5.2.2 Making an appointment

Patients are more likely to arrange an appointment by telephone than in person. As a result, there were far fewer examples of appointment requesting than of checking in (N34). The approach most frequently adopted by patients (71%) was the use of a stereotypical polite request with one of the interrogative forms 'can I' and 'could I', accompanied just over half the time by the politeness marker 'please' (see Biber et al. 2002: 433). Several other forms of face threat reduction were also used, as shown in Table 5.11: one or another combination of the items in the first three columns was always present whereas the items in columns 4 to 7 all appeared to be optional.

Table 5.11: Appointment bids

<table>
<tr><th>1</th><th>2</th><th>3</th><th>4</th><th>5</th><th>6</th><th>7</th></tr>
<tr><td>can/could I</td><td rowspan="5">make
get
have</td><td rowspan="6">an appointment</td><td rowspan="6">to see
with
for</td><td rowspan="6">doctor/
nurse</td><td rowspan="6">today
next week
on the 7th</td><td rowspan="6">please</td></tr>
<tr><td>I was wondering if I can</td></tr>
<tr><td>I'd like to</td></tr>
<tr><td>it was just to</td></tr>
<tr><td>I've to</td></tr>
<tr><td colspan="2">I want/am wanting</td></tr>
<tr><td colspan="5">any chance of me seeing</td><td></td><td></td></tr>
</table>

The forms shown in column 1 below " can/could I" show the style of mitigation which was used. The choice with the highest level of unreality and distance (see Leech ibid.), and consequently the highest level of protection for both speaker and hearer, is 'I was wondering if I can', which is shown in context in Extract 5.6.

Extract 5.6

(Practice A, Disc 4, 3-33, F/26-40/ly/ey)

PA77: okay . em . I was just wondering . em . I used to live here . but I'm just visiting . and I was wondering if I can have a visitor's . em . appointment

This patient, as she herself indicates, is a visitor to the practice and does not have the automatic right to be given an appointment. The increased imposition/threat to her own face which this involves is the main reason why her conventional request is more indirect than normal, combining the unreality of the verb 'wonder' and the conditional 'if' clause, the distance of the past tense ('was wondering') and the possibility of 'can' with hesitation markers ('em') and a mitigated explanatory account ('I'm just visiting').

Bids are also made using other modalised expressions. In one case the modality of possibility is encoded in the noun 'chance', ('hello . is there any way- . chance (.) of me seeing Dr Mertoun this week?', Practice A, Disc 3, Track 2, 04-23, M/61-75,). Three patients make their bids using deontic rather than epistemic modality, signalling that they must perform the activity. One presents the bid as a necessity ('I need to make an appointment with the nurse for some blood tests', Practice C, Disc 2, 30-38, M/26-40) and two more make 'obligation statements' (Blum-Kulka et al. 1989) (e.g. 'I've got to make an appointment with the nurse . it's oh . for about two weeks', Practice B, Disc 2, Track 1, 32-43, M/41-60/lw/o). All three patients in this group have been asked to make appointments, following on from consultations, and protect their own face by attributing responsibility to the doctor or nurse. At Practice C volition, in the form 'I'd like to' (e.g. PC35: I'd like to make an appointment to see Dr Nash please, Practice C, Disc 1, 64-53, no questionnaire), is also twice used as a marker of conventional politeness.

The ideas of needing and wishing are also present in four bids in which the verb 'want' is used, each time with a different effect because of contextual variation. Two of these bids are made by non-native speakers, who may not be familiar with the politeness norms of English, while one is used in response to an extremely direct

elicitation (as shown in §5.2.2, Extract 5.1). The one remaining patient who uses the verb 'want' (Extract 5.7) makes his bid in the vernacular Scottish style (see Miller 1993), using a present progressive verb form.

Extract 5.7

(Practice A, Disc 1, 09-08, M. No details)

RA1: hi there

PA6: I'm wanting an appointment to see a doctor

This bid is an unusually direct expression of the speaker's wants, which shows no evidence of face protection for either speaker or hearer. It is difficult to gauge the effect of different requesting styles on receptionists, since patients are entitled to receive appointments and cannot be refused on the grounds of requesting style alone. However, receptionists do have a gatekeeping role which is seen most clearly in the discretion which they exercise over the allocation of appointments. In other words, receptionists can decide which patients will be given priority. Receptionist RA1 does not respond to the appointment request in Extract 5.7 by giving patient PA6 the same-week appointment which he subsequently asks for. Instead, she instructs him to call the practice later in the day, purportedly 'when the computer releases more appointments' (see also §6.1.2 and §7.1). And yet, although there have been no cancellations in the interim, within the next forty minutes she gives one patient a same-day appointment and two others same-week ones. This suggests either that patient PA6 has been pre-typified as undeserving (see e.g. Schutz 1962; McKinney 1969; Husain-Gambles 2004), or that his unmitigated requesting style had a negative impact.

There are several other more direct forms of bid. In two cases patients soften their impact with 'just' (e.g. 'it was just to make an appointment', Practice B, Disc 2, Track 1, 09-34, F/16-5/lm/om) which, according to Quirk et al. (1985: 598) is an attitude diminisher which "seek[s] to imply that the force of the item concerned is limited" and for Aijmer (2002: 174) "a downtoning hedge modifying speech acts which threaten the delicate social balance between speakers and hearers". In two others, speakers use present progressive forms to make their bids, on both occasions

after the opening turns have been occupied by the exchange of consent forms and questionnaires. These examples are shown in Extract 5.8, in which the patient is an older man, and Extract 5.9, in which the speaker is from Ghana.

Extract 5.8

(Practice A, Disc 3, Track 3, 55-08, M/75+/ly/om)

PA73: (.) I'm looking for an appointment . with Dr Mertoun . Denis Wyatt

Extract 5.9

(Practice B, Disc 2, Track 1, 11-01, M/41-60/lw/om)

PB48: that's fine . that's okay (8) can I state my problem please (.) em . I'm actually . making an appointment for Dr Hubble

The present progressive is most likely to be used for description of events in progress (Biber et al: 2002). By adopting it, the speaker in Extract 5.8 distances himself slightly from his own proposition, which is otherwise quite direct. As well as containing a present progressive bid, Extract 5.9 is prefaced by a pre-request, 'can I state my problem please', which is both conventionally polite and formal in speech style. This might be a variant cultural norm for a patient from another culture (see e.g. Spencer-Oatey 2000) but is more likely to have been prompted by the eight second delay after research forms have been exchanged. The discourse particle 'actually', which in medial-initial position, as it is here, marks a revision of a prior assertion and a speaker's wish to change the hearer's perspective (Aijmer 2002; Clift 2001), and the corrective present progressive 'I'm making' both mark the patient's reaction to the receptionist's failure to acknowledge, within the expected time frame, that he is at the practice to obtain a service. In this view, the conventional politeness of the pre-request serves to mitigate a stronger than normal face threat to the receptionist, since there is a criticism implicit in it.

5.2.3 Collecting a repeat prescription

The distribution of approaches used during prescription collection suggests that patients have more than one understanding of the level of face threat to both self and

other which is generated by a prescription claim. The different styles used by patients who are collecting prescriptions (N56) are set out in Table 5.12.

Table 5.12: Prescription collection bids

<table>
<tr><td rowspan="5">1</td><td rowspan="2">can I
could I</td><td rowspan="4">collect
get
have
pick up</td><td rowspan="6">a prescription
prescription</td><td rowspan="5">for +
name</td><td rowspan="5">address</td><td rowspan="6">please</td></tr>
<tr></tr>
<tr><td>2</td><td>it’s just to
just come to</td></tr>
<tr><td>3</td><td>I’ve to
I’ve got to
I was to
X asked me to</td></tr>
<tr><td>4</td><td>I want to</td></tr>
<tr><td rowspan="2">is there
do you have
have you got
is my</td><td rowspan="2">in
ready</td></tr>
<tr><td>is</td><td>my
(name)’s</td></tr>
</table>

As in appointment requesting, when collecting prescriptions patients are most likely to use a conventional polite request (group 1, 39%) but there is also a sizeable percentage of direct claims (group 4, 28%) while mitigation (group 2, 12%) and the modality of obligation (group 3, 22%) are also used. The politeness marker ‘please’ is chosen only occasionally (5 times each at Practices B and C) and there is also one example of anticipatory ‘thanks’ at Practice B. Those making direct statements treat prescription collection in the same way as the majority of appointment claimants treat checking-in and the same types of contrast between low (Extract 5.10) and high (Extract 5.11) levels of information provision can be observed.

Extract 5.10

(Practice A, Disc 3, Track 3, 40-57, M//61-75/lm/esm)

PA68: right . e::h (1) prescription

Extract 5.11

(Practice B, Disc 3, 25-02, F/16-25/o/om)

PB86: hi . I'm here to actually pick up three pres- . prescriptions . one for Gordon James (.) one for Gillian Petrie and one for Thomas Petrie . and they're all at five stroke seven Glasgow Street

Patients using the conventionally polite, mitigated or modalised approaches seen in groups 1 to 3 seem to feel that there is a greater level of imposition involved in prescription collection. This is perhaps because repeat prescription slips allow patients to obtain physical products, possibly without making any payment[37], or perhaps because searching for a prescription slip is thought to involve more work for a receptionist than finding a patient's name on a list.

5.2.4 Ordering a repeat prescription

There is only a small number of applications for repeat prescriptions made at the counter (N12). With the exception of one, non-standard, choice of wording, all are shown in Table 5.13.

Table 5.13: Prescription request bids

<table>
<tr><td>just</td><td>waiting to hand in
gonna hand in
handing in
need to give you
want to hand in</td><td rowspan="3">a prescription
a repeat prescription
some lines
that
this</td><td rowspan="3">please</td></tr>
<tr><td colspan="2">I'm putting in</td></tr>
<tr><td colspan="2">could I put in
I wonder if I could do</td></tr>
</table>

The most routine formulations of this request are very brief and include the downtoner 'just', which has already been discussed in relation to appointment requests (e.g. 'just to hand that in' Practice A, Disc 1, 49-29, F. No questionnaire). There are only two patients who make direct statements which are not mitigated in this way. Both are produced after lengthy preambles in which the research paperwork is dealt with, both using the present progressive verb form 'I'm putting in', one

[37] Sihota (2003) points out that around 85% of prescription items are dispensed without charge.

preceded by the discourse particle ‘actually’, and seeming to mark a change of direction in the same way as the present progressive appointment requests in Extracts 5.8 and 5.9.

There are also two conventional polite requests, the more elaborate of which, ‘I wonder if I could eh . do a repeat prescription please’ (Practice B, Disc 1, 65-52, M/41-60/lm/om) is produced by a patient who has forgotten to bring his prescription card to the practice and must ask the receptionist to find the electronic record of the four items which he needs, thereby generating a far higher level of imposition. The patient who requests the largest number of repeat prescriptions uses the most unusual face-saving device, combining positive politeness and indirectness in providing remedy. This is shown in Extract 5.12.

Extract 5.12

(Practice A, Disc 3, Track 3, 18-54, F/41-60/there for others/om)

RA6: can I help you?

PA63: aye . you’re gonna love me (.) Ashburton Grove

PA63 has come to the practice to hand in a group of repeat prescription applications on behalf of the tenants of a sheltered housing complex. She constructs her face-protecting bid in three units. First, PA63 responds directly to the receptionist’s offer with the acceptance token ‘aye’, using a vernacular Scottish style which is also a characteristic of the receptionist’s speech. This rapport-builder is followed by further construction of solidarity, partly through the joking ironic comment ‘you’re gonna love me’, which flouts Grice’s (1975) Maxim of Relation, creating the implicature that the opposite is meant, and then by the indirect explanation in the two words ‘Ashburton Grove’ which, it is assumed, the receptionist will recognise as the name of a sheltered housing complex. The patient protects her own face by showing her awareness that the long prescription list entails a face threat to receptionists, on account of the increased workload it brings. She protects the face of the receptionist by providing remedy indirectly and building solidarity through attention to feelings.

5.2.5 Additional remedial features in service bids

There are several additional features of patient responses to service signals with implications for face protection. As shown in Chapter 4, although receptionist-patient greeting behaviour is by no means fully reciprocal, patients do sometimes open with the supportive ritual of a greeting. In addition, about fifty per cent of patients reduce the commitment to their bids in a number of ways while almost half of all patients responding to receptionists' service offers preface their bids with acknowledgement tokens.

Although receptionist greetings were returned by patients only 45% of the time, patients initiated greeting rituals in an additional 27% of encounters. Around 40% of receptionists at Practices A and B returned these patient greetings but only 15% at Practice C. It was unusual for direct mirroring to take place. This was the case for only 16 of 89 greetings (18%). The formal greetings 'good morning' and 'morning' were most often mirrored, the informal 'hiya' the least. 'Hi there' from the receptionist was more likely to be followed by 'hi', which was the dominant choice for female patients, possibly reflecting its frequency in everyday conversation. Patients initiated greeting mainly when they took the first turn at talk (60%), but 30% of patient-initiated greetings followed elicitors. This pattern was most common at Practice A where the one word elicitor 'yes' followed a greeting six times out of nine (66%). In contrast, greetings followed offers only four times in all the encounters in the data.

Although patients used the same greeting types as receptionists, the frequencies differed, as shown in Table 5.14. The most common choice for patients was 'hi', the token which occurs most frequently in everyday interaction (Biber et al 2002: 453). The informal 'hiya' was also used more by patients than receptionists, as were the formal 'good morning' and 'good afternoon', while the use of 'morning' and 'hello there' was at similar levels. Finally, 'hello' was used around half as often by patients as by receptionists and 'hi there' one third as often, adding further weight to the view that they are the greeting forms most closely associated with synthetic signalling.

Table 5.14: Comparison of receptionist and patient greetings

Greeting type	Receptionist %	Patient %
hi there	30	10
hello	24	14
hi	17	41
morning	15	14
hiya	9	13
hello there	2	2
good morning	1	4.5
good morning . hi there	1	-
good afternoon	-	1

Despite the marked differences between patterns of greeting use for receptionists and patients, as Table 5.15 shows, there were also similarities.

Table 5.15: Patient greetings by practice

Greeting	Practice A	Practice B	Practice C	Total
hi there	1	3	5	9
hi	12	16	10	38
hiya	5	5	2	12
hello there	-	2	-	2
hello	3	2	8	13
morning	8	4	1	13
good morning	1	1	2	4
good afternoon	-	1	-	1
Total	30	34	28	92

The tendency towards an informal style ('hi' and 'hiya') already noted among receptionists at Practices A and B was shared by patients at these practices, while the more formal 'hello' form was more used at Practice C. More surprisingly, there was much more use of the formal 'morning', 'good morning' and 'good afternoon' by patients in the more deprived areas, perhaps because this is perceived as an appropriate register for an encounter with a health-service professional.

There is no evidence that the age of the patient has an effect on the choice of greeting but, in line with both Holmes' (1995) suggestion that women are more likely to use positive, rapport-oriented politeness than men and Iacobucci and Ostrom's view that female consumers prefer a 'communality approach (see §2.3.1), male patients tended to use formal greetings more than female ones. Men produced only 5 of the 38

tokens of 'hi' which were used (13%) but, despite being outnumbered by female patients at a ratio of 3 to 2, they accounted for almost half the use of the more formal choices, 'morning', 'good morning' and 'good afternoon' and 40% of the use of the more formal 'hello'. However, they also chose the informal greeting 'hiya' (5 tokens) almost as frequently as female patients (6 tokens).

Approximately half of all patients also showed attention to face either by increasing the tentativeness of their bids through the use of hesitation markers such as pauses, filled pauses (e.g. eh, em, er) and prolongations of syllables, or by reducing the commitment to their propositions through the choice of verb (e.g. I think, wonder, believe; I don't know; I'm not sure) or internal questions (e.g. was that? who's it with?), discourse markers (as I say, I mean) and vagueness (sort of, like). These avoidances of full commitment to the propositional content of utterances attend to the face needs of receptionists by reducing the force of bids, but they also protect the self-images of patients, since reduced certainty means less loss of face in the case of error. This may be why these features are more common in checking-in and prescription collection, in which patients make stronger claims than in requests for appointments and repeat prescriptions, in which there is negotiation.

Finally, about half of patients increased attention to face by augmenting their cooperativeness through the provision of acknowledgement tokens in response to service signals formulated as polite offers. This is illustrated in Extract 5.13.

Extract 5.13

(Practice B, Disc 1, 20-44, F/ 26-40/lm/om)

RB3: hi . could I help?

PB13: aye . I've got an appointment with Dr Moyles . at ten o'clock

The use of the acknowledgment token attends to the face needs of the receptionist by indicating that the statement which follows has a positive polarity, so making it easier for her to process.

5.2.6 Summary

When patients make service bids their relational awareness is reflected predominantly in the remedial work which is carried out. Three main forms of remedial approach are used: formulaic politeness, mitigation, and claims that actions are obligatory or necessary. Although there are some differences between patients' approaches at the three practices, the widest variations are between face protection strategies for different activity types, confirming the view that the activity type is a valuable unit of analysis for linguistic politeness (Culpeper 2005). If it is accepted that levels of remedy are indicators of perceptions of imposition, it can be said that requesting an appointment represents the greatest imposition and checking in for an appointment the least. When patients check-in for appointments their bids are almost always direct, which may also reflect a perceived need to account for attendance. Patients who are handing in applications for repeat prescriptions use less remedial language than those who are collecting them, perhaps because more work is required from the receptionist, or perhaps because they expect to receive a physical prize, the prescription, as a result of the collection routine.

Some patients also give attention to the relational side of their interaction with the receptionist by reciprocating or initiating supportive greeting rituals or acknowledging polite offers before going on to make service bids. In addition, many patients use avoidance approaches, either increasing the tentativeness or reducing the levels of commitment to their bids. Like receptionists issuing service signals, most patients make their bids through the routine use of conventional forms. However, like some receptionists, a few patients make their utterances more individual through small variations in the statement of task objectives.

5.3 Minor infringements

When social interaction takes place, infringements of social expectations and norms are inevitable. These infringements constitute a greater than usual threat to the face

both of those who commit them and those affected by them and, when they occur, higher levels of provision of verbal remedy are to be expected. Goffman (1971) believes that remedy is required to offset both minor and major disruptions of the social order, observing "whether one runs over another's sentence, time, dog or body, one is more or less reduced to saying some variant of 'I'm sorry'" (1971: 118). As Goffman's comment suggests, the simplest form of remedy for an infringement is an apology. Apologies are produced when offences are thought to have been committed and are therefore, as Robinson (2004: 6-7) states, "social claims to have offended someone and communicate awareness and acceptance of moral responsibility for offensive behaviour" (see also Edmondson 1981, Holmes 1990).

An apology can be enacted in a number of ways (see Owen 1983). The only direct method is through the performative verb 'I apologise', which is also an illocutionary force indicating device (Olshtain and Cohen 1983) but the most commonly used forms are ritual expressions of regret ('sorry', 'I'm sorry') and requests for pardon ('I beg your pardon', 'pardon me', 'pardon'). In conjunction with the apology, fault may be admitted and apologies may also be replaced or supplemented by accounts, which Scott and Lyman (1981: 348, n.4) divide into two groups: justifications, "if the actor giving it takes responsibility for the behaviour in question", and excuses, "if the actor divorces him- or herself from responsibility". Furthermore, the apologising party may continue to produce accounts until relief (Goffman 1971) or absolution (Robinson 2004) is granted.

There are four types of minor offence in the data: discourse problems, which can be attributed either to receptionists or patients; procedural omissions, which are unique to patients; delays, for which both practices and patients can be responsible; and non-provision of appointments, again the responsibility of practices. There is also a group of infringements which are more serious: mismanagement of prescription use by patients and maladministration of appointments, prescriptions or test samples by practices. This latter group will be discussed in Chapter 7. When offences are committed varying amounts of remedial talk are provided, including the provision of apologies and accounts, sometimes alone and sometimes in combination. Sometimes

also there is no provision of remedy, which may indicate that offenders do not consider that it is necessary in the circumstances or, alternatively, that they are not aware of the error.

5.3.1 Discourse offences

Slip-ups such as mishearings, misstatements and false starts are common in talk-in-interaction and are treated by conversation analysts as events requiring discourse repair (Schegloff, Jefferson and Sacks 1977). The details of this type of offence in the present data are shown in Table 5.16, together with an indication of the forms of remedy which are used.

Table 5.16: Remedy for discourse offences

Offence	R/P	Remedy					
		Practice A		Practice B		Practice C	
mishearing	R	pardon/sorry	1	sorry	5	sorry zero	2 1
	P			sorry pardon zero	1 1 1	pardon I beg your pardon sorry	2 1 1
misstatement	R	sorry	1	sorry	1		
	P	sorry I'm sorry/sorry about that	1 1	sorry	1	sorry	1
forgetting	R	sorry	2				
	P					I'm sorry	1
interruption	R	zero	1				
	P	sorry	1				
inattention	R			oh sorry	1	oh sorry	1
TOTAL			8		11		11

(R: receptionist; P: patient)

Discourse infringements are fairly evenly distributed across practices, although there are slightly more than one might have expected at Practice C in proportion to the number of consenting patients. Just under two-thirds of discourse infringements are committed by patients and just over one third by receptionists. In remedy, a majority of both receptionists (80%) and patients (64%) use some form of "sorry-based unit[s]

of talk" (Robinson 2004) which, Aijmer (1996: 97) suggests, is "not only appropriate for trivial offences, but also serves as a disarmer or softener, as an attention-getter and as a phatic act establishing a harmonious relationship with the hearer". There are also several instances of the use of 'pardon' (receptionists 1, patients 3), one patient at Practice C (from the oldest age-group) uses the formal 'I beg your pardon' while no remedy is provided by 20% of receptionists or 12% of patients. In the case of inattention the discourse marker 'oh' precedes the apology, indexing the change in the speaker's mental state.

The most common infringement is mishearing, for which the ritual remedial moves also function as requests for repetition. This is demonstrated in Extracts 5.14 ('sorry?') and 5.15 ('I beg your pardon')

Extract 5.14

(Practice B, Disc 1, 11-03, M/41-60/lm/6 weeks)

1	RB2:	morning
2	PB7:	hi pal . I don't know if it's ten o'clock or ten past ten with
3		Dr Robin Ritchie . er Mr Dolphin . Brian Dolphin
4	RB2:	what was the name? sorry?

Extract 5.15

(Practice C, Disc 2, 12-48, M/75+/lm/esm)

1	RC2:	yes
2	PC50:	I wonder if there's another one there . that's for paracetomols . I get
3		one for . cholesterol
4	RC2:	(3) did you request it?
5	PC50:	I beg your pardon

The remedial nature of 'sorry' and 'I beg your pardon', in which the speaker takes responsibility for the infraction, is made more obvious when they are contrasted with the unmitigated imperative forms ('mm?','come again') of the repetition request which are used by two speakers at Practice B. The latter is illustrated in Extract 5.16 (line 2).

Extract 5.16

(Practice B, Disc 3, 26-00, No details))

1 RB4: and have you got a house of your own in the area?

2 PB87: come again

3 RB4: (*careful speech*) you have a house in this area?

Although the patient did not complete a questionnaire, it was apparent that she was a non-native speaker, and may therefore have had a different set of politeness norms.

Patients also sometimes provide accounts as remedy when discourse errors are made. For example, when a patient mistakenly thinks he is being addressed by a reception who is speaking on the phone, he provides an unlikely justification, 'I've relatives in Belmont Street' (Extract 5.17, lines 2/3), accompanied by two short bursts of mitigating laughter (see e.g. Jefferson 1979; Brown and Levinson 1987).

Extract 5.17

(Practice C, Disc 1, 44-32, M/61-75/lm/esm)

1 PC30: (*hears RC2 on phone saying 'your name is?'*) Finlay (*hears R2 saying '3*

2 *Belmont Street is it?*') (…) hahaha (unclear words) . yes . I've relatives

3 in Belmont Street so . what's that . he he he . oh .

5.3.2 Procedural omissions

Three further groups of offences are the result of non-performance, or gaps in patients' knowledge, of front desk procedures. Non-performance or omission of an expected discourse move, such as non-provision of name, making the service bid without delay or providing necessary information, is treated by most patients in the same way as a slip-up and repaired with a brief ritual apology, but there are four occasions when patients provide explanatory accounts, either as well as or instead of apologies. The distribution of these offences by practice is shown in Table 5.19.

Table 5.17: Remedy for procedural omissions

	Practice A		Practice B		Practice C	
omission of information	oh sorry sorry + account	1 1	sorry account	3 2	sorry zero	1 2
omission of procedure	account zero	1 1	I'm sorry	1		
unaware of procedure	account zero	1 2	sorry . sorry	1		
TOTAL		6		7		3

A patient's reaction when he realises that he has not provided necessary information is shown in Extract 5.18, while Extract 5.19 is an example of a patient apologising for failing to bring in his repeat prescription card. In both examples the patients appear to interpret their omissions as offences because they have failed to fulfil the obligations of the patient role.

Extract 5.18

(Practice A, Disc 2, Track 1, 00-07, M/41-60/lw/ow)

RB2: and who's it for?

PB32: oh sorry . it's for my wife

Extract 5.19

(Practice B, Disc 1, M/41-60/lm/om)

1 PB34: hiya . I wonder if I could eh . do a repeat prescription please

2 RB2: mhm . if I can find them || they were here

3 PB34: || I never brought my card in . I'm sorry

The apology in Extract 5.19 is a self-initiated self-repair, seen by Schegloff, Jefferson and Sacks (1977) as the preferred form of correction. It is followed by the apology token 'I'm sorry', whereas 'oh sorry' in Extract 5.18 is an apology which responds to an other-initiated repair, threatening to the face of the addressee and, to a lesser extent, the speaker.

The other-initiated form of repair seen in Extract 5.18 is illustrated more clearly in Extract 5.20, in which the receptionist makes a three part initiation of repair (line 3),

to which the patient replies with both a ritual apology and a comment in mitigation (line 4).

Extract 5.20

(Practice A, Disc 3, Track 3, 53-05, F/41-60/lm/om

1 RA6: yes . hello
2 PA66: I've just to (.) re- . remind him he's to phone me
3 RA6: remind . who am I meant to be reminding? . Dr?
4 PA66: MacLaverty . yes sorry (.) I'm just expecting you to know! . er that . on
5 Monday . he's gonna phone me about eleven o'clock
6 RA6: right . so what did he say to you . for . you've to say to me to remind
7 him?

The receptionist's blunt request for additional information (line 3) in this example is completely unmitigated and no relief is given after remedy has been provided. This lack of acknowledgement of the face needs of the patient suggests impatience and exasperation rather than a service ethic or a concern to maintain relationship. In contrast, the patient's uptake of the repair, which involves both an apology and a self-blaming account, suggests that she accepts the implied rebuke and is attending to the receptionist's face. However, a few moments earlier the same receptionist has been involved in a remedial exchange, shown in Extract 5.21, which is quite different.

Extract 5.21

(Practice A, Disc 3, Track 3, 51-55, F/41-60/lw/om)

(*service orientation*)

1 PA71: och I forgot to put a number on them (*repeat prescription request forms*)
2 RA6: oh aye . you'd better put the number on eh
3 PA71: och it's (?cold out) (*sighs*)
4 RA6: (3) (two words unclear)
5 RA6: that's fine
6 PA71: I keep dropping things with the arthritis in that hand {RA6: aye} it's a bit
7 clumsy right enough
8 RA6: you're alright

The patient here provides an excuse, 'I keep dropping things…' (lines 6/7), in remedy for her slowness in attaching the number sticker, provided by the practice, to her repeat prescription request. The receptionist, who has already given relief (line 2) to the patient for her initial failure to attach the sticker through a supportive tag question (see Holmes 1982), provides relief (line 8) after the account for her slowness, which is personalised by the use of the second person of the verb 'be' rather than taking the more common impersonal form, 'it's alright'.

5.3.3 Delays

Both receptionists and patients are also involved in offences connected with timing. Receptionists can be slow to offer service, patients arrive late and consultations are not given at the appointed time. The patterns of remedy for this type of offence are shown in Table 5.18.

Table 5.18: Remedy for delays

	Practice A		Practice B		Practice C	
patient waiting	sorry sorry/sorry sorry + account	3 1 1	sorry account zero	1 1 1	sorry zero	1 2
TOTAL		5		3		3
patient late	zero	1	zero	1	I've to apologise zero	1 1
TOTAL		1		1		2

There are seven receptionist apologies when patients are kept waiting, one also with an account, and one single account. Examples are shown in Extract 5.21, in which the receptionist is apologising for the delay which has taken place because she has been speaking on the telephone for several minutes to patients requiring appointments, and Extract 5.22 (line 4), in which the receptionist provides an account in the form of a justification ('trying my best') for the unusual length of time it is taking to find a repeat prescription.

Extract 5.21

(Practice A, Disc 2, Track 2, 35-41, M/61-75/lm/esm)

RA3: yes . sorry about that

Extract 5.22

(Practice B, Disc 1, 24-11, F/41-60/lm/esm)

1 RB3: ‖ hi . can I help?

2 PB15: ‖ hi . it's to pick up a . prescription please . it's a repeat prescription .

3 Helen Donaghue

4 RB3: right (28) trying my best

Both the apology in Extract 5.21 and the account in Extract 5.22 seem to be given because there is one patient who has been waiting for an exceptionally long time. I noted in my field journal that many patients were obliged to queue for several minutes before receptionists were able to serve them, particularly at Practice A, where incoming telephone calls for appointments were always taken by the one receptionist working at the front desk, yet, for most of these delays, neither apologies nor accounts were provided. Whereas the receptionist in Extract 5.21 dissociates herself from the cause of the delay by using the distal demonstrative pronoun 'that', the one in Extract 5.22 personalises her account by using the first person possessive 'my' (see also §6.1.2).

Only four patients arrived late for appointments. One provided remedy with the performative verb 'I apologise' but, as shown in Table 5.20, the other three offered neither apology nor account. This may be because the apology is due to the doctor rather than the receptionist, but it also suggests that, although it is acknowledged, lateness is perceived by most patients to be a mentionable rather than an accountable matter and is treated no differently from arriving early, as illustrated in Extracts 5.23 (late arrival) and 5.24 (early arrival).

Extract 5.23

(Practice B, Disc 1, 54-03, M/41-60/ly/2-3 months)

RB3: can I help?

PB31: yeah . I'm a bit late . (?I want) Dr Ireland . I think it was twenty past te:n

Extract 5.24

(Practice C, Disc 3,Track 2, 67-00, F/26-40/lm/esm)

RC3: hello

PC89: hi . I'm early actually . for an appointment with . doctor

The lateness of a GP seems to have a similar status. Although I also noted that surgeries frequently ran late, this is only mentioned once (Extract 5.25), without apology or account, and only because the patient, who is late herself, asks about it.

Extract 5.25

(Practice A, Disc 2, Track 2, 69-04, F/26-40/lw/om)

PA55: I'm a bit la:te (2) give you that (*consent form*) (1) e:h . I've got an appointment at ten to

RA3: (7) right . it's Dr MacLaverty room four . if you take a seat he'll give you a call when he's ready

PA55: is he . is he late or

RA3: (1) he's running a wee bit late . he's no that bad || though

PA55: || good

It appears that the patient asks the question as an indirect means of finding out if she has missed her appointment, rather than in further mitigation of her own offence. The receptionist minimises the doctor's lateness state both with the vague quantifier 'a wee bit' and the litotes, 'he's no that bad', with its implication that GP lateness can be much worse, but it appears that this is a statement of fact rather than a provision of remedy.

5.3.4 Appointment problems

The final form of minor infringement considered here is the failure on the part of the receptionist to meet an appointment need immediately. There are eight examples of this at Practice A, four at Practice B and only one at Practice C. As Table 5.21 shows, on most occasions (77%) accounts are provided but there are no apologies.

Table 5.19: Remedy for non-availability of appointment

	Practice A		Practice B		Practice C	
no appointment available	account zero	6 2	account	4	 zero	 1

The accounts given are mainly excuses (doctor on holiday, appointment list not made up), although there is one justification in the form of an acknowledgement of shared responsibility, "we don't have anything until about next Wednesday" (Practice B, Disc 3, 54-36, F/41-60/o/o). The provision of accounts protects the face of receptionists while the absence of apologies disregards the face needs of patients. In contrast, one patient who is unable to accept an appointment offer does give an apology ('no . sorry . I can't make that' Practice C, Disc 3, Track 2, 04-31, F/41-60/ly/ey), perhaps because her non-acceptance of the proposal will lead to further work for the receptionist.

5.3.5 Provision of relief

The provision of relief is a sign that remedial action has been accepted, as shown in Extract 5.26, in which there is extensive relief in the form of reassurances from the patient (lines 3-4).

Extract 5.26

(Practice A, Disc 1, 53-28. No details)

1 RA1: (*calls patient from waiting room using first name*) sorry to keep you waiting
2 . I just couldnae quite get || to shout on you there
3 PA24: || it's alright . as long as I get em
4 (*prescriptions*). that's alright

Relief is given in this form by either receptionists or patients three times at Practice A, once at Practice B and four times at Practice C. In addition, as seen above, speakers occasionally alleviate interactional discomfort either with affiliative laughter or by producing supportive comments (twice at Practice A, twice at Practice B, once at Practice C). The use of laughter is well illustrated in Extract 5.27, in

which the receptionist joins the patient's remedial laughter before breaking off (line 9) to return to the task focus.

Extract 5.27

(Practice B, Disc 3, 37-14, F/41-60/lw/om)

1 RB6: hi there
2 PB90: hi . got an appointment for: Robin Ritchie at twenty to ↑two
3 RB6: aha
4 PB90: or twenty to three sorry
5 RB6: what was your name || please
6 PB90: || hhhh . Alison Alda
7 RB6: hh hh
8 PB90: ha || ha ha ha ha ha
9 RB6: || ha ha ha ha . right Alison

In Extract 5.28 we see a receptionist teasing the patient with a joking comment (line 4) to relieve his embarrassment, when he remembers that he is at the front desk to hand in a prescription request not, as he has initially stated, to collect one.

Extract 5.28

(Practice B, Disc 2, Track 1, 15-04, M/41-60/y/ow)

1 PB62: (2) (*groans*) (1) it's to put one in actually . just remembered
2 RB2: to put it in?
3 PB62: aye . just remembered
4 RB2: (.) ha . trying to confuse me Mr Kennaway? (.) what's your address
5 again?

The style of relief is in keeping with the dominant tone of the encounter. In the Service Orientation stage the joint attention to business has been accompanied by relational elements (an informal greeting, 'hi', from the receptionist, the use of the in-group identity marker, 'pal', by the patient). The patient cues his repair of the mis-statement not verbally but with an emotion marker, the groan at line 1 and gives no apology but a double justification, 'just remembered' (lines 1 and 3). The joking comment also claims common ground (see Brown and Levinson 1987) but, in

keeping with the institutional nature of the encounter, it is counterbalanced by the receptionist's use of the patient's formal title, which restores the social distance between them. It is also again the receptionist who resumes the task focus when she asks for the patient's address after providing relief.

Robinson (2004) claims that apologising can only be viewed as the primary action of a turn when relief is subsequently provided. The low incidence of relief in response to apologies in the data suggests that apologies for minor infringements are oriented to by most receptionists and patients as non-salient, secondary actions. This finding is not unexpected with regard to remedy for discourse errors or verbal omissions, which, as Robinson also shows, are mainly treated as secondary in talk, but it is perhaps more surprising that only one of the seven apologies offered when patients are kept waiting is followed by relief. This may be seen as a further sign that patients are more intent on pursuing transactional goals than on sustaining relationships with receptionists.

5.3.6 Summary

Most receptionists and patients provide remedy when discourse rules are infringed, reflecting their common orientation towards shared cultural practice. When procedural errors are made, most patients also make remedial moves, sometimes in response to initiators of repair from receptionists which have shown no attention to face needs. Delay is not generally treated as a matter for remedy. Receptionists do not apologise for most delays, although apologies and accounts are provided when delays are in some way exceptional. Similarly, only one of the four patients who arrive late apologises to the receptionist. The failure to provide a suitable appointment leads to accounts from most receptionists but is never accompanied by an apology. In contrast, a patient who is unable to accept an appointment offer does apologise.

5.4 Conclusions

The preceding analysis shows that, in the opening stages of encounters and in response to minor infringements, relational matters are mainly attended to by receptionists and patients through the use of short, routinised remedial rituals, much as they were in the service encounters observed by Goffman (1983). The presence in the data of a range of relational formats also supports Grainger's contention (2002) that linguistic politeness choices in healthcare contexts reflect both the ambiguity of institutional roles and the nature of the work being done and McCarthy's (2000: 90) assertion that the relational side of discourse in genres, is "of equal relevance to the achievement of goals as the transactional "staging" of predictable elements". As predicted, there are variations in usage which appear to reflect social variation between practices, the personal styles of individuals, the differences between activity types, the respective roles of receptionists and patients and interpretations of situational rights and duties.

When giving service signals, most receptionists display idiosyncratic relational styles but there are also practice by practice tendencies with, at Practice A, a preference for the use of rapport-building supportive rituals with little conventional politeness, at Practice B a mixture of rapport-building and conventional politeness and, at Practice C, a leaning towards either conventional politeness or the use of, more direct, elicitors. The performance of service signals suggests that the approaches taken at Practices A, B and C fall somewhere between client-centred and bureaucratic formats. The use by receptionists of greetings and polite offers implies that, as envisaged in The Patient's Charter (McNab 1999), the patient is being treated as a valued customer (see also §2.1.1), whether through informal rapport, synthetic personalisation or the more traditional means of conventional politeness. However the high incidence of unmitigated, direct, forms, particularly at Practices A and C, suggests a bias towards an impersonal bureaucratic format. The directness may be the result of the cognitive overload (Cicourel 2004) experienced by receptionists as they try to complete a range of different task types simultaneously but it nevertheless highlights the difference between the institutional approach, in which scant attention

is accorded to relational matters as state-funded services are delivered (Sarangi and Slembrouk 1996), and the commercial one, in which money buys 'service' as well as services.

The amount of face-protective language produced by a majority of patients when making service bids, notably for the appointments which allow them entry into the therapeutic system, but also for receptionist-administered repeat prescription services, seems to indicate respect for the authority of receptionists, an interpretation which is reinforced by the many signs of hesitation and tentativeness in the discourse of patients. The patterns observable in the provision of remedy for minor infringements supply further insights into participants' interpretations of their situational rights and duties. Patients almost always atone for minor procedural errors with remedial relational talk, suggesting that they consider themselves under an obligation to perform in an institutionally competent manner. However, they do not generally apologise when they are late for appointments, suggesting either that lateness is perceived as an offence against doctors rather than receptionists, or that it is not important because surgeries rarely run to time. The latter view is supported by the absence of receptionist apologies for delays, other than in exceptional circumstances. Delays are a routine matter and do not therefore require remedy. This also seems to be true of the service shortfall which occurs when an appointment cannot be provided immediately, suggesting that there is no understanding that patients have an entitlement to rapid service.

It has been shown that, although receptionists intend to be helpful, patients often find them obstructive or unfriendly (see §2.1.2.). One reason for this may be differing perceptions of the forms of relational behaviour which are appropriate in the context (see Mills 2003; Locher and Watts 2005). Although few patients show signs of interactional discomfort or voice objections to the style of service provision, it may be that the mere lip-service paid to relational practice by some receptionists is considered inadequate. Research also shows that receptionists often feel that patients are rude, uncooperative or unappreciative, a view which was supported by conversations and interviews with the receptionists who took part in this research.

The data suggest that there is only a minority of patients whose discourse might be regarded as inappropriately inattentive to face concerns, but observations by the research assistants suggest that the patients who seemed less likely to show regard for the face needs of receptionists were also less likely to give consent to have their front-desk encounters recorded.

Only three features of front desk discourse have been considered in this chapter but the relational tendencies observed here extend to all areas of receptionist-patient interaction. For instance, supportive and remedial rituals are also present in other stages of encounters but very rarely do receptionists or patients move out of the task frame or engage in exclusively interpersonal small talk. More will be said on these points in Chapter 6, when the discourse roles and identities of participants are discussed in more detail, and in Chapter 7, when the discursive construction of both remedial rituals and participant identities is examined through an analysis of three encounters in which patient problems are resolved.

Chapter 6

The discourse roles and identities of receptionists and patients

6.0 Introduction

In Chapters 4 and 5 receptionists and patients were seen in their primary roles, respectively as service seekers, who wish to have health problems resolved, and purveyors of services, who are able to provide access to solutions, but there was also evidence in the relational discourse of participants of the complex and shifting representation of identity which takes place in talk as participants foreground different aspects of their social and personal selves. As outlined in Chapter 2 (§2.2.2), as they co-construct interaction speakers categorise and position both themselves and others, changing frames and footings and displaying the roles, or identities, which are salient for them at the time of speaking.

Roles and identities are indexed by discourse decisions at all levels, from phonological choices to lexico-grammar and discourse organisation. Here I concentrate on three areas which clearly reveal the positioning of receptionists and patients. First, I consider how participants deictically situate both themselves and others through person reference; second, I discuss aspects of the identity work performed by variations in speech style; and third, I show how participants add to the performance of roles, or the representation of self, through changes of topic. Throughout the chapter I bear in mind the third research question: "What do variations [in discourse patterns] reveal about the participants' construction and understanding of the interaction?".

6.1 Person reference

Duszak (2002) points out that the 'us-them' relationship is an aspect of social deixis which has a central role in identity construction. The relationship is conventionally marked by indexicals such as forms of address and pronouns, which reveal the

'production format' which is adopted (Goffman 1981: 145). Speakers are, in the first instance, first persons (I/we) and addressees second persons (you) but, as Wales (1996) points out, pronominal reference does not correlate simply with speaker roles. Any of the personal pronouns can be used by a speaker for self-reference while, in English, address forms are used to express solidarity and power relations which are covered by second or third person pronominal reference in many other languages (Brown and Gilman 1972). For this reason, I will first analyse forms of address, as indicators of how speakers position themselves in relation to their addressees, and then pronominal reference, as one of the keys to understanding how speakers represent themselves.

6.1.1 Forms of address

The three main styles of address are 'zero address', in which no vocative form is used, respectful forms such as title-plus-surname or deference marker, and forms such as first names, diminutives, endearments and solidarity markers, which suggest either familiarity or intimacy (see Biber et al. 1999).

The omission of a form of address is relationally the most neutral approach, since it avoids any expression of relationship or of status difference. Titles and deference marker are conventionally used by those in subordinate positions to address those with greater power or higher status (Ervin-Tripp 1972; Laver 1974), but may also be deployed in remedy for face threats (Brown and Levinson 1987; Holmes 2001; McCarthy and O'Keeffe 2003). First names, according to McConnell-Ginet (2003: 78) are "used reciprocally between people who are close to one another or non-reciprocally down a hierarchy" but, as both McConnell-Ginet and Bargiela et al. (2002) point out, there is a great deal of contextual and cultural variation. For example, in a trend which is associated by Bargiela et al. with synthetic personalisation and is seen by McConnell-Ginet (2003: 79) as a general progression in the direction of a "solidarity semantic", Americans and Britons under the age of 40/50 increasingly prefer to move immediately to these equalising terms, whereas

speakers in non-Anglophone cultures remain more status and hierarchy-oriented (see also Biber et al. 1999).

Patterns of usage for terms of endearment and solidarity markers also vary according to the context and to the speech groups to which speakers belong. For example, Wolfson and Manes (1980: 90) observed that in commercial service encounters in large stores in the United States, while male customers were routinely addressed as 'sir', implying respect or deference, the endearment 'dear' which, in their view, "parallels usage by adults to children and often signals condescension",were commonly used with females. They attributed this variety to the ambiguous situation of a service encounter, in which the customer, to whom service is given, is also dependent on service personnel, whom one might expect to be subordinate, for the transaction to take place. In contrast, McConnell-Ginet (2003: 85) points out that there are also situations in which different social values are attached to terms of endearment, suggesting that there are "still English-speaking communities of practice in Britain where some of these endearments apparently function in much the same way as general terms like *guys* or *dude* or *folks*". (McConnell-Ginet adds that, in these same communities of practice, solidarity markers such as 'pal' are used to signal in-group membership.)

The main forms of address which occur at Practices A, B and C are, among receptionists, titles ('Mr' or 'Mrs' plus surname), deference markers ('sir'), first names, and terms of endearment ('dear', 'hen', 'love') and there is also one "familiarised first name" (Biber at al. 1999: 1108); among patients there is one solidarity marker ('pal') and several different terms of endearment ('darling', 'dear', 'hen', 'kiddo', 'love', 'pet'). However, at the front desks of all three practices, the use of a form of address is a marked choice since, in the majority of encounters (and turns), 'zero address' is used (64% of encounters at Practice A, 52% at Practice B and 97% at Practice C). These high percentages also suggest that, although, as Biber et al. (ibid.) point out, vocatives can also serve discourse management functions such as attention-getting and identification, between receptionists and patients, the social function is salient. Hence, although there are two examples from Practice A of a

receptionist summoning a patient by name from the waiting area, these have not been included in the quantitative analysis below.

Patterns of use at the three practices will be considered in turn, first for receptionists and then for patients. The first choice for receptionists at Practice A is the zero address form (64% of encounters). First names and title plus surname are used in about equal measure, accounting respectively for 46.5% and 36.5% of the use of address forms, while terms of endearment and deference markers account respectively for 7% and 10% of use. However, it should be noted that, despite the fact that 67.5% of the patients addressed are female, almost 81% of first name/endearment use is directed towards them whereas the 32.5% of patients who are male account for 64% of the use of titles and deference markers. These patterns are set out in Table 6.1.

Table 6.1: Use of forms of address by receptionists at Practice A

Receptionist	Zero		First name		Endearment		Title + surname		Deference marker	
	F	M	F	M	F	M	F	M	F	M
RA1	7	4	8	3	-	-	1	2	-	-
RA2	2	4	-	-	-	-	1	1	-	1
RA3	11	3	-	-	-	-	1	1	-	1
RA4	1	3	-	-	-	-	-	-	-	-
RA5	2	1	-	-	-	-	-	-	-	-
RA6	15	-	2	-	2	-	1	1	-	1
M/F TOTAL	38	15	11	3	2	-	5	6	-	3
TOTAL	53		14		2		11		3	
Percentage of encounters	64%		36%							

The table shows how different receptionists favour different styles. In the small number of encounters in which they are involved, RA4 and RA5 never use direct address forms, while RA2, RA3 and RA6 use them very little. As already mentioned, it was reported by receptionists that this is the most practical approach, since it ensures that mistakes with names will be avoided. However, RA1 frequently uses first names, particularly with female patients, even when she does not know them,

and also occasionally title plus surname, twice with males and once with a female patient. RA2, RA3 and RA6 also all use titles, once each to address one male and one female patient, and deference markers, once each with male patients. In addition, RA6 addresses two female patients whom it is clear that she knows personally, in one case by her first name and in the other with an endearment (see §5.1.1).

As Table 6.2 shows, the address practices of receptionists at Practice B are in some ways similar to those at Practice A, since the most frequent choice by receptionists is the omission of a direct address form (52%) but first names, endearments, titles and deference markers are also used in a fairly high percentage of encounters.

Table 6.2: Use of forms of address by receptionists at Practice B

Receptionist	Zero		First name		Term of endearment		Title + surname		Deference marker	
	F	M	F	M	F	M	F	M	F	M
RB1	11	12	-	-	-	-	-	2	-	-
RB2	10	5	2	-	-	-	-	5	-	2
RB3	6	-	6	1	-	-	-	3	-	-
RB4	1	2	2	2	10	7	1	1	-	3
RB5	1	1	-	-	-	-	-	-	-	-
RB6	6	4	9	2	-	-	-	-	-	1
M/F total	35	24	19	5	10	7	1	11	-	6
TOTAL	59		24		17		12		6	
Percentage of encounters*	52%		48%							

* The use by RB4 of a combination of endearment with first name, deference marker or title is taken into account.

There are fairly similar levels of use of first names at Practices A and B (41% of address forms at B and 46.5% at A), less use of titles at B than at A (20% at B, in contrast with 36.5% at A), and more use of terms of endearment (29% at B as opposed to 7% at A), while the levels of use for deference markers are identical (10% at each practice). There is again a strong tendency for deference markers and titles to be used more to address males, of all ages, than females. Only 49% of patients addressed are men and yet 100% of deference markers and 92% of titles are

applied to them while 71% of first name or endearment use is directed towards the 51% of addressed patients who are female.

The high levels of use of terms of endearment at Practice B is entirely due to the interactional style of RB4, who uses endearments 17 times to address patients. While RB4 routinely uses 'dear', sometimes more than once in the same encounter, to address patients of most ages and both sexes, familiar and unfamiliar, she uses 'love' to address the one patient she deals with who is aged between 16 and 25 and 'hen' for a patient whom she seems to know well. In addition, on seven occasions RB4 uses either a first name (2), a title plus surname (3) or a deference marker (2), in the same encounter as an endearment thus, in the latter two cases, creating a hybrid relational style which combines positive and negative politeness. RB3 and RB6 both have more clearly defined rapport-oriented styles and make frequent use of first names, regardless of the familiarity of the patient, whereas RB2 is more inclined to use respectful forms, title plus surname or the deference marker 'sir', when addressing patients directly and uses first names only with patients whom she knows. Finally, RB1 twice uses the title 'Mr' while RB5, for whom there are only two examples, uses no names at all.

The use of address forms by receptionists at Practice C can be summed up very quickly, since they occur only 4 times. With the exception of RC2, who addresses two male patients aged over 75 and one female aged between 16 and 25 as 'dear', and RC1, who addresses one elderly male patient as 'sir', zero address is used all the time.

Overall it can be seen that, as in other aspects of their talk, receptionists have routine personal styles of address use but occasionally make adjustments in response to individual patients. As might be expected, a relationship can be seen between the level and style of forms of address used by receptionists and their preferred styles of opening. The receptionists who open encounters in the rapport-centred style represented, for example, by the ritually intoned greeting 'hi there', are more likely to use the first names of patients whereas those who adopt a formal stance when

giving service signals are more likely to use deference markers and titles (see §5.1, Table 5.2). (Consistent with the findings of Bargiela et al., the receptionists who routinely use the rapport-centred, first name address style are all under under 45.) The findings for receptionists at Practices A and B also strongly suggest that they react differently to male and female patients. Like the service personnel in the Wolfson and Manes study, they are inclined to show deference to male patients but with females use first names or terms of endearment, which may be designed to build solidarity or communality but can also be interpreted as over-familiar or patronising when there is no previous relationship between participants.

The other notable feature of the use of address forms by receptionists is the marked difference between Practice C and the two other practices. When contrasted with the mixture of forms used approximately half the time at both Practices A and B, the near avoidance of vocative forms at Practice C points to a style which is less personal, in so far as individual patients are not clearly differentiated through naming. This may be explained by the achievement orientation/efficiency ethos of the practice but it is also likely to reflect both the less solidarity-oriented social practices of its predominantly middle class patients (see e.g. Milroy 1980) and the lack of rapport displayed by receptionists and their colleagues behind the scenes. There is also evidence that receptionist C2 treats patients in the oldest and youngest age groups less impersonally. The use of terms of endearment with these groups may be seen, as in the Wolfson and Manes study, as indexing a power differential in favour of the receptionist, in which case she appears to have a slight tendency to treat the elderly and the young as subordinate, or the use of terms of endearment may be seen, as McConnell-Ginet observes, as a marker of rapport. Whichever the case, some members of both the oldest and youngest age groups are singled out by RC2 by the change in her naming practices.

Not surprisingly, since it is unlikely that most patients know the names of receptionists, who did not wear name badges at any of the three practices, there is only one example of a patient addressing a receptionist by name (Practice B, Disc 3, 13-58 and 35-40, M & F/61-75/ly/ey), and this seems to be because they are old

friends, who are on first name terms. However, terms of endearment are used, in approximately the same proportions, by patients at both Practices A and B. They are used by 8 patients at Practice A: 6 male (darling, hen, dear, pet), four of them over 61 years old and all of them over 40, and 2 female (hen, dear), both aged between 41 and 60, while at Practice B they are used by 11 patients: 8 male (love, pal, kiddo, hen, darling, dear), six of them over 61 years old and all of them over 40, and 3 female (hen, darling), two aged between 61 and 75 and one over 41. The three tokens of the solidarity marker 'pal', one at Practice A and 2 at B, are all from male patients. At Practice C, patients are similar to receptionists in using address forms very little and presumably for the same reasons: only one patient addresses the receptionist as 'dear'.

In the majority of cases, the use of terms of endearment by patients seems to mark a solidarity-based interactional style, which is indexed even more clearly by the in-group identity marker 'pal'. This is particularly true of male patients in the older age groups, as in the case of PA31, who makes more than one use of 'dear' (Extract 6.1, lines 3 and 5).

Extract 6.1

(Practice A, Disc 1, 69-53, M/41-60/lw/ew)

1 PA31: I'm just gonna put some lines in

2 RA2: (*hands questionnaire to patient*)

3 PA31: thank you dear

4 RA2: and put it in the box when you've (.) completed it

(…)

5 PA31: is that right dear? . thank you (*passes over prescription requests*)

The term of endearment appears to be a habitual means of reinforcing face-saving moves, boosting the thanking move (line 3) and mitigating the request to have the prescription order checked (line 5).

There is also one clear example of the use of an endearment as an attitude marker and two occasions when terms of endearment seem to play a part in the attainment of transactional goals. The attitude marker use is shown in Extract 6.2, in which the patient signals his strong appreciation of the work RB6 has done to sort out his housing problem by affectionately using the intimate term 'darling' (see §4.4.6 for the beginning of this encounter).

Extract 6.2

(Practice B, Disc 3, 18-14, M/61-75/lw/om)

RB6: that's you sorted then

PB81: thanks darling . really

In Extract 6.2 the patient uses the endearment when he has already achieved his task goal but in Extract 6.3 the patient, also male, is yet to attain it. The extract begins at the point when the patient has reported that there is an item missing from his repeat prescription form. This leads the receptionist to explain that only doctors can modify prescriptions.

Extract 6.3

(Practice A, Disc 2, Track 2, 04-09, M/41-60/lm/om)

RA2: well I need to get a doctor to do it. so what is the name of the tablet?`

PA35: pet . I can't remember (2) I'm no a good reader . I just taen them you know (.) I was looking for the box this morning (1) I noticed it was (?missing) but I'm no a very good reader . so it- I couldnae remember the name of them (*sniffs, sighs*) so it's just the new one that's just been || two months

RA2: || I'll just check your record {PA35: yeah} hold on a minute (*phone starts ringing*) (6) Tramadol (3) Tramadol it's called

PA35: yeah . aye

RA2: no but if I say that (.) you can remember if anybody asks . it's Tramadol (2) there we ↑go . that be Wednesday . is that okay?

PA35: yeah

RA2: in the afternoon

The use by PA35 of the endearment 'pet' as an attention getter and disarmer in phrase initial position (line 2), the only example in the data of an address form in this position, both clears the way for the patient's lengthy turn (see Biber et al. 1999) and introduces the discursive construction of an inexpert self (lines 2-5) which culminates in the patient attaining his transactional goal. (This encounter is analysed in detail in §7.1.)

In summary, patients have less choice than receptionists in the use of forms of address, since they have no way of knowing receptionists' names, whereas receptionists do know theirs. However, an alternative form of naming was found by 17 of the 273 consenting patients, who used terms of endearment or solidarity markers when addressing receptionists. In some cases this appeared to be a habitual means of rapport-building and part of the type of solidarity-based politeness package which is found among speakers of colloquial Scottish varieties; in others it served specific functions such as expressing appreciation or paving the way for problem solution.

6.1.2 Pronouns

Coupland and Coupland (2000: 209) suggest that pronominal address and reference are "probably the most obvious and the most powerful linguistic features used to mark relational frames". They also, as Pennycook (1994) among others has shown, reveal the balance of power between speakers and through them, as Drew and Sorjohnen (1997: 97) observe, "participants may display their orientation to their acting as incumbents of an institutional role". Pronouns vary in meaning according to the functional contexts in which they are used (Mühlhäuser and Harré 1990), making it difficult to determine their precise referents. Goffman (1981) observed that 'I' may refer to more than one figure, or persona, and may be the principal, the author or the animator of what is said depending on the footing which is adopted (see §2.2.2) while, of 'we', Wales (1996: 63) remarks that its discourse referents "are seemingly limitless".

Receptionists and patients use both first person singular (I, me, my) and first person plural (we, us) for self-reference. Subject pronouns are sometimes deleted to give expressions such as 'help you?', 'just give you this' or 'got an appointment', and, as shown below in Extracts 6.4, 6.5 and 6.6, agency is sometimes attributed to third person entities when self-reference might have been expected. The self-referential practices of patients are fairly straightforward. Although many make elliptical statements in which the subject pronoun is omitted, and a small number use the pronoun 'we' when representing other family members, the majority use first person singular pronouns and possessives[38]. Receptionists, in contrast, assume different footings for different actions, sometimes in the course of the same encounter, or the same turn. While it is impossible to be sure exactly what a speaker intends, since 'we' in particular is a "shifting signifier" (Wales 1996: 62), contextual factors suggest that receptionists use first person pronouns for the referents listed below:

I^1- non-institutional self
I^2 - representative of institution
we^1 - I and all other people
we^2 - I and patient
we^3 - I and receptionist colleagues
we^4 - the medical practice.

These choices indicate whether personal responsibility is assumed, responsibility shared or agency attributed elsewhere and, when correlated with the different actions which are performed, provide insights into receptionists' interpretation and understanding of their roles. An outline of receptionist practice is given in Table 6.3. (Patterns of use for individual receptionists are shown in Appendix 4, p.461.)

[38] These can, of course, represent more than one aspect of their identities (Silverman and Torode 1980; Mühlhäuser and Harré 1990).

Table 6.3: Pronoun use by receptionists

Activity	1st person s.	1st person p.	3rd person s/ p.
Front desk tasks	I^1 & I^2	-	-
Apologies	I^2	-	-
Patient problems	I^2	we^2, we^3 & we^4	-
Appointment allocation	I^2	we^3 & we^4	various
Registration/procedures	I^2	we^4	various
Comments	I^1 & I^2	we^1 & we^2	various

Contextual factors suggest that for front desk tasks such as making service offers (e.g. can *I* help you?) and issuing instructions (e.g. just take a seat for *me*), or in routine apologies for locally generated errors (e.g. *I'm* sorry about that), a receptionist's 'I' should be interpreted as I^2 (the representative of the institution). When carrying out these tasks, receptionists appear to draw on the authority they are granted in their "special capacity" as institutional representatives to act as authors and animators of an institutional voice (Goffman 1981: 145). When patients bring problems to the desk, while receptionists continue to use this voice, they also use 'we', which seems to stand for we^3 (I and receptionist colleagues). When allocating appointments, receptionists again use 'I' and 'we' for I^2 and we^3 but, in some cases, appear to further reduce direct personal responsibility either by using 'we' in the we^4 sense (the medical practice) or by attributing agency to the practice computer. 'We' also seems to be used in the we^4 sense during registration or when practice rules and procedures are explained. There is also intermittent use of the personal I^1, we^1 (I and all other people) or we^2 (I and the patient), in which the speaker is principal as well as animator and source. However, receptionists are rarely animators only since there is hardly any use of scripts at any of the three practices.

How this variation works in practice is demonstrated first in an analysis of pronoun use during appointment allocation and, second, through a consideration of the institutional and interpersonal functions of the self-referring comments of receptionists. In the first example of appointment allocation, Extract 6.4, the receptionist seems to be speaking in the I^2 voice, in her institutional role (lines 3 and 5).

Extract 6.4

(Practice C, Disc 2, 03-33, M/75+/lm/om)

1 PC40: hi there (.) I've to make an appointment with the nurse . for a blood test
2 for two weeks
(*receptionist checks details*)
3 RC2: ri:ght . I can give you nine o'clock . or eight forty's the first appointment
4 PC40: nothing later?=
5 RC2: = the latest being . eh . nine twenty . or I can give you . eh (.) the
6 afternoon at one thirty

RC2 takes personal responsibility for the appointment allocation and there is no separation of individual and role. Appointments are presented either as independent entities using the verb 'be' ('eight forty's the first', line 3 'the latest being', line 5) or in the receptionist's gift ('I can give you', lines 3 and 5), in an open acknowledgement of gate-keeping power. In contrast, as Extract 6.5 (line 3) shows, RA4 appears to make a distinction between the institutional position and her personal performance.

Extract 6.5

(Practice A, Disc 3, Track 2, 01-49, M/61-75/lw/esm)

1 RA4: hello!
2 PA58: hello . can I see the (.) Dr MacIntyre on the (.) seventh
(*receptionist checks details*)
3 RA4: (.) now we'll see what we can do . I don't know whether I've got that

RA4 begins by using the collective *we*, which can be interpreted as the voice either of the practice or of the reception team, or even as a marker of solidarity with the patient, but, when she turns to the physical task of finding an appointment slot in the computer diary, switches to an in-role first person singular. One can infer from the alternation between 'we' and 'I' forms that RA4 accepts shared involvement in practice responsibility. This is made clear when one contrasts her approach to appointment-making with the position she adopts when dealing with research forms (see also §8.1.1). As Extract 6.6 shows, she triply distances herself from the research

process by using the adverb 'apparently', the deontic modality of 'I've to', both of which indicate that responsibility for the action lies elsewhere, and the demonstrative pronoun 'that', which also expresses distance.

Extract 6.6

(Practice A, Disc 3, Track 2, 00-28, M/61-75/lm/ey)

RA4: (*hands questionnaire to patient*) apparently I've to give you that

There are also three receptionists who distance themselves from appointment decisions by passing responsibility for availability to clinical staff. This is illustrated in Extract 6.7 (line 3), in which receptionist RC1 uses the pronoun 'he' to refer to Dr Green, who has already been mentioned by the patient.

Extract 6.7

(Practice C, Disc 2, 28-20, F/No details)

1	PC51:	can I make an appointment with Dr Green for myself maybe {RC1: yes}
2		some time next . maybe next Wednesday . or whatever else
3	RC1:	(1) next week (2) he's got next Tuesday at . four-twenty . next Wednesday
4		morning at nine fifteen or nine twenty-five

Receptionists at Practice A sometimes go further. As Extract 6.8 shows, not only do they sometimes avoid the use of the role-specific I^2 but they may also show a Latourian willingness to attribute agency to the computer, which becomes a participant in an "actor-network" alongside human agents (see Latour 2005).

Extract 6.8

(Practice A, Disc 1, 09-08, M. No details)

1	RA1:	hi there
2	PA6:	I'm wanting an appointment to see a doctor
		(*receptionist checks details*)
3	RA1:	no (2) for any day: this week Donny you'd need to phone at quarter past . eh
4		. half past three . that's when the computer releases more appointments
5		for each d- . day . you know . the following day . other than that we're
6		looking (.) maybe a week ahead {PA6: aye} what do you prefer to do?

7 PA6: er (.) I prefer it this week

8 RA1: you prefer it this week?

9 PA6: aye

10 RA1: if you could give us a call (.) maybe half past three today for tomorrow then

The receptionist in this encounter goes through several perspective shifts. In what is the only example of a receptionist taking the footing of animator, since the formulation of non-availability has been devised by the practice manager for receptionist use, RA1 begins by attributing responsibility for appointment availability to the computer (line 4) and telling the patient, who is marked by the use of the 'familiarised first name' as well known to the receptionist, what he is therefore obliged to do ('you'd need to', line 3). Subsequently, however, as a short negotiation is carried out, she aligns herself with the patient ('*we*'re looking') and then, after he has stated his preference for an early appointment, with reception or practice colleagues ('if you could give *us* a call', line 10). By attributing responsibility to the computer, the receptionist disguises her power to allocate appointments (see §2.2.4), distances herself from the situation in which an appointment is not immediately available, and thereafter constructs herself as, like the patient, unable to do anything about this when, in reality, she has a number of appointments in her gift.

However, as Extract 6.9 shows, RA1 does not always construct agency in this way. In this encounter, she seems to move towards a greater acknowledgement of personal agency as she decides to give the patient an appointment in the same week.

Extract 6.9

(Practice A, Disc 1, 52-15, F/61-75/lm/esm)

1 PA14: eh . can I make an appointment for the doctor please?

(*receptionist checks details*)

2 RA1: right . for any day this week what I'd need to ask you to do is phone at half

3 past three when the computer releases the appointments for the next day

4 PA14: oh

5 RA1: other than that || we're looking (.) at the ↑following week

6 PA14: || mhm . so phone every day at half three?

7 RA1: phone at half three for tomorrow . tomorrow for Wednesday etcetera
8 {PA14: mhm}or I can look ahead to next week if you want (.) or would you
9 prefer to try for || this week
10 PA14: || we:ll . have you got anything next week – (?female or
11 anything)
12 RA1: I might have got . (?just a wee second) . have a look at Thursday
13 P14: no it disnae matter || I'll just phone every day
14 R1: || er:m . sorry I'm just checking to see {P14: (?aha)}
15 thought I had one there but (.) it's not (7) I've got Friday {P14: mhm} I can
16 give you half past three with Dr Cochrane- . er half past one sorry . with Dr
17 Cochrane

Initially RA1 uses the distancing 'I'd need to' (line 2), suggesting not only that she is subject to the control of the computer, which is mentioned in the next line, but that there are other forces controlling her actions. There again follows a collective 'we' (line 5), which seems to include both the receptionist and the patient, but the receptionist then switches to 'I' (lines 8, 12, 14 and 15), possibly after she has made the decision that she will find an appointment for the patient, as she continues to use it until a suitable appointment has been found. In other words, she identifies more closely with the positive outcome for the patient than the negative one.

The 'I' used by RA1 in the last example seems to lie somewhere between I^2 and I^1 since the receptionist can be seen as personally doing this patient a favour. It is thus in the middle of the institutional/personal cline of self-representation. The same is true of the occasional observations about task performance, such as the reflective gloss made by RA4 on her own fulfilment of an appointment request, "*I'm* squeezing you in" (Practice A, Disc 3, Track 2, 04-23, M/61-75/lw/every two weeks). In making this comment RA4 presents herself as working hard to help the patient and making a benign use of her gate-keeping power (and at the same time exerts pressure on the patient to accept the appointment which is offered). There is another group of comments in which the receptionist's 'I' has a similar function. These are the *sotto voce* remarks, such as '*I* wonder if', 'let *me* see', which are made while receptionists are carrying out tasks in the presence of patients. These self-directed utterances,

which Goffman (1981: 79) named "self-talk", (a category which, in the present data, also includes occasional reactive outlouds such as 'whoops' and 'o:::h' and extended pause fillers such as 'dudududududu' and 'labadabaday') put the patient into the role of bystander, or "targetted overhearer" (Levinson 1988), rather than ratified addressee. However, they belong to the soliloquy genre since, although monologic, they are uttered in the presence of an audience to whom something of the inner world of the speaker is deliberately revealed. They can therefore be seen as an additional resource for the demonstration of institutional competence since, by using them, receptionists are able to display their commitment to serving the transactional interests of patients.

Another group of receptionist comments in which first person reference is used contributes to the building of positive institutional relationships. This includes expressions such as 'there *we* go' (Practice A (10)), 'there *we* are' (Practice B (1), Practice C (2)) and 'here *we* are' (Practice B (1)), which are used as alternatives to the more frequent, and more socially distant, 'there *you* go' when prescriptions or questionnaires are handed to patients. Following Brown and Levinson (1987), Mühlhäuser and Harré (1990: 186) describe these routine phrases, which are recurrent features of the linguistic enactment of the receptionist role rather than individualised responses to interactional events, as 'interactive' and 'phatic'. They are a further example of the conventionalised rapport-building, which has already been observed in other features of front desk talk. So too are the commentaries on current (e.g. *I'm* just checking') or near-future (e.g. '*I'll* get that for you', *'I'll* just check it') actions. Receptionists are acting in role but showing consideration for patients' 'positive' face by supplying non-essential information and adding a personal element.

In counterpoint to these routine expressions, a more personal voice seems to be heard when receptionists show empathy after patients have made mistakes. This was the case for RB2, when she joked 'ha . trying to confuse *me* Mr Kennaway', after the patient has misstated his reason for coming in to the practice (see §5.3.5). Other instances include the alignment of RC3 with a patient who has forgotten her child's

date of birth, by admitting to a similar blind spot, '*I'm* hopeless with numbers' (Practice C, Disc 3, Track 2, 4-31, F/41-60/ly/ey) and the positioning of RA1 in the same category as a patient who has run out of medication for a chronic condition, by using a first person plural pronoun in her rapport-building remark, "such a busy time eh . *we're* forgetting" (Practice A, Disc 1, 39-50, F. No details).

Patterns of pronoun use by receptionists are so fluid that they are impossible to quantify but it is nevertheless evident that, although there are no overall differences between practices, individual receptionists approach their work in different ways. For example, apart from one time when she uses 'we' to reassure a patient that a prescription request will be processed by receptionists ('*we'*ll get this one ready'), RC2 always uses 'I'. Similarly, except when referring to research forms, receptionist B6 also invariably uses 'I', while receptionist C3 frequently adopts 'we', or passes agency to a third person. Both of the latter two styles of pronoun use are consistent with these receptionists' comments made during interviews: RB6 treated reception work as a profession and expressed a high degree of personal commitment to carrying out her work efficiently, whereas RC3 stated that she was in the job only because she was not qualified to do anything else and was not paid to take personal responsibility for practice decisions. In these terms it therefore seems entirely understandable that RB6 almost always uses the first person singular whereas RC3 attributes agency to a third person or shares it with others.

6.1.3 Person reference and discourse identity

The use of forms of address by receptionists is an additional feature of their 'relational practice' (Fletcher 1999; Holmes and Schnurr 2005) and the variations in individual choice, like those already observed in service signals, contribute to the identity style which each receptionist projects for the role. The patterns of use observed for address forms confirm the findings of Chapter 5: some receptionists take an approach which leans towards social solidarity and rapport, while others routinely maintain social distance, a third group move between these dominant styles and others maintain neutrality. There are again examples of stylistic changes which

appear to mark responses to individual patients or groups of patients (e.g. age and gender groups), and further evidence that there are major social and institutional differences between Practice C and the other two practices.

Following Bourdieu (1977a), Hanks (1990: 15) maintains that all deixis is "oriented to and constrained by the asymmetric distributions of cultural capital (in the form of prestige, knowledge and sanctioned access to recognised modes of speaking, rights over space and objects)". The use of a name or title is a form of cultural capital which is available to receptionists but not to patients. The asymmetry between the two groups is particularly salient when receptionists address patients by their first names. It is the more powerful member of a dyad who instigates asymmetric address. Hence, when receptionists use a first name in addressing a patient, it can be seen as a means by which they imply that patients are subordinate, not only to receptionists themselves but also to doctors, whose formal titles are always used during interaction between receptionists and patients. However, when receptionists use deference markers or titles, they reduce the asymmetry by placing themselves in a position of subordination. The small number of patients who make use of terms of endearment or solidarity markers redress the imbalance created by the unequal distribution of knowledge of names, at the same time indexing their transportable social identities (see §2.2.2) and finding additional support in the pursuit and attainment of transactional goals

Receptionists, and occasionally patients, use different pronouns, sometimes within the same turn at talk, to mark changes of footing and changing degrees of acknowledgement of agency. These appear to depend on the type of activity in which they are engaged. All receptionists take personal responsibility for the performance of front-desk work routines but some are inclined either to index shared institutional responsibility for gate-keeping decisions about appointments, particularly negative ones, and patient problems, or to point to a third person agent. On the other side of the same coin, they may take credit for successful appointment allocation or solution of problems. In their self-directed utterances and commentaries on task enactment, receptionists use subjectivity as a means of representing themselves as committed

performers of their institutional roles, while the use of first person pronouns in the speech routines through which they accomplish their work add to the rapport-orientation of their performance. In contrast, in the comments which show empathy with patients who have made mistakes, they appear to construct themselves as caring individuals, who treat patients as persons rather than depersonalised clients.

6.2 Speech styles

Each speaker has a dominant dialect but styles are modified in response to changing situations, activities and addressees (see Bell 1984; Trudgill 1992). This was demonstrated in Chapters 4 and 5, in which it was shown firstly that, although front desk activities are mainly accomplished through the repetition of a limited group of stages and moves, there are variations both between the speech acts which are chosen and their styles of enactment and secondly that, although most participants draw on a limited set of forms, a few use items which are not otherwise heard. One can infer from this not only that there is a register (see e.g. Biber 1988) which is typical of front desk encounters but also, in Goffman's terminology, that some types of discourse figure, or persona, appear more frequently in front desk encounters than others. Furthermore, bearing in mind Ochs (1992) proposal that linguistic features constitute, or index, social dimensions and positions, or the view of Torras and Gafaranga (2002) that language choices are membership categorisation devices, it can be said that the language choices which are made less often index identities which are non-standard for the front desk context.

The dominant dialect for all but 3 of the 16 receptionists and 2 assistant receptionists who were recorded is some form of Scottish English, the exceptions being one speaker of Yorkshire English (Practice A), one of educated southern English and one of American English (both at Practice C). The 283 participating patients have a very wide range of dominant varieties. The majority are Scottish with speakers mainly of Standard Scottish English (SSE) at Practice C and speakers mainly of local dialect versions of Scottish English at Practices A and B (see Macaulay 1997; Robinson and Crawford 2001). There are also patients who speak non-Scottish forms of English: 2

patients at Practice A and 3 at Practice B speak regional variants of English while 23 patients at Practice C have Received Pronunciation (RP) and a smaller group includes 1 Australasian, 1 southern African, 1 north American and 1 Irish English speaker. There are also several non-native speakers with Asian (Practice B (1), Practice C (1)), African (Practice B (3)) and European mother tongues (Practice C (4)).

6.2.1 Variation in style

The number of encounters in which each receptionist is involved makes it possible to observe patterns of variation in their speaking styles. Although there has not been a systematic examination of all the variation in the data, two points stand out. First, receptionists at Practices A and B adopt more formal styles when communicating with patients than they do when talking to one another and, second, when dealing with patients, receptionists at all practices make small turn by turn, or encounter by encounter, adjustments in style, increasing or decreasing formality and including varying quantities of colloquial and local dialect items. The following examples from the speech of receptionist A1 demonstrate these points.

The first example (Extract 6.10) is an illustration of the style used by RA1 when talking to her colleagues backstage. Informal language is to be expected in backstage talk (Goffman 1969) but in this extract, RA2 is not only speaking to a colleague but also emotionally engaged by the task and consequently uses the most informal of her speech styles as represented on the recordings (see e.g. Labov 1972a).When the encounter was recorded, the two receptionists were standing in the front desk area but were involved in 'off-task' talk (Holmes and Stubbe 2003) about an order for artificial Christmas trees. RA1 believed she had ordered a tree which was covered with small stars but had received one with only one star on top.

Extract 6.10[39]

1 RA2: you see (.) Alma shouldnae a took the sample away

[39] Apostrophes represent glottal stops except in words such as 'I'm', 'I'll' or 'Alma's' where they are conventional .

2 RA1: I know || I know
3 RA2: || because that woulda le' us all see {R1: that's right} and I just
4 assumed when he handed i' in on the Friday {R1: aye} that was it=
5 RA1: =tha' was the same a- . eh . I was . so I wonder if everybody's go' the same
6 (.) || I'm wan'in (.) I'm wan'in the starzh . I'm wan'in the wee starzh .
7 RA2: || well that's the same as mine
8 RA1: it's the wee starzh tha's (2) have yi go' the (?sheet there)
9 RA2: well I'm- I think yi'll nee' a look n see cos I'm only . I'm only . that
10 says Christmas star {R1: aye} so it's only a star
11 RA1: no Alma's ez no . Alma's ez go' starzh . wee snowdrop kinda starzh . all
12 over it
13 RA2: right . well no- . nobody opened them on Friday
14 RA1: she shouldnae a took it

Features of colloquial Scottish speech to note in the phonology are the use of glottal stop for /t/ and /d/, /ʒ/ for /z/ in the word 'stars', /ə/ for /tə/ and /əv/, /ji/ for /ju/ and, in the lexico-grammar, 'shouldnae' for 'shouldn't', 'took' for 'taken', 'wee' for 'small' and 'aye' for 'yes' (see MacAfee 1982/1992; Miller 1993; Macaulay 1997). There is also an informal, high involvement style (Tannen 1984) with both latched and simultaneous talk while, in addition, rather than fluently producing routine sequences as she does when enacting her receptionist role, RA1 seems to experience difficulty in putting her point across, as the truncated utterances, repetitions and restarts all show (e.g. lines 5-6, 9-10).

The example shows that the casual style used by RA1 with colleagues includes many local Scottish dialect features. At the opposite end of her stylistic spectrum is the formal style which she uses during telephone calls. The style was most marked in encounters which took place shortly after recording began, suggesting that the receptionist was also influenced by her awareness of the microphone and the imagined wider audience. A taste of this style is given in Extract 6.11

Extract 6.11

1 good morning . reception . Isabel speaking . how can I help? (5) you're looking for

2 Dr Howard. I'll just check for you . can you hold the line please? (18) hello there . er
3 Dr Howard's first one is (.) Christmas Eve. the twenty-fourth . at nine ten (3) you
4 cannot make that (.) a:::h (*sighs, sucks in breath through teeth*) you can't make
5 Christmas Eve at all? (.) right (.) the next one after that would be the twenty-seventh
6 at four o'clock . Friday (9) a Friday (4) yeah that's in between Christmas and New
7 Year (4) the following one? (.) right (.) after that would be the thirtieth (1) or the
8 thirty-first (.) that's all I've got on his screen at the moment (3) you want the
9 thirtieth . now that's a Monday (.) nine twenty? (*typing*) (.) that okay for you? (.)
10 what's the name? (*typing*) (2) and date of birth please? (3) that's fine (.) that's nine
11 twenty on Monday the thirtieth with Dr Howard for ya (.) okay . thank you . bye bye

Apart from the interjection, 'a:::h' and sigh (line 4), the pronunciation of 'yes' as 'yeah' (line 6), the ellipsis of 'is' in the clause 'that okay for you?' (line 9) the pronunciation of 'you' as 'ya' (line 11) and the informal leave-taking 'bye bye', the official style is maintained throughout. The production is fluent, consisting of complete clauses and lexical chunks, and the lexico-grammar is formal, as indicated by items such as the greeting 'good morning' (line 1), the polite offers 'how can I help?' (line 1) and 'can you hold the line please?' (line 3), the full verb form 'cannot' (line 4), and the choice of 'following' (line 7) and 'nine twenty' (line 9) rather than more informal cognates. Comparison of the discourse in Extract 6.11 with other examples of telephone talk from RA1 show that this style is always dominant, although there are some examples which contain more colloquial or informal features than this one. One can say that during telephone calls RA1 is using her most managed institutional voice.

In contrast, in face-to-face encounters RA1 uses a style which includes many local dialect items. Some examples are Scottish lexical (e.g. 'aye', 'wee') and grammatical features (e.g. 'cannae', 'disnae', 'isnae', 'havenae', 'you've no') and phonological ones such as 'yi' for 'you' and 'ti' for 'to'. However, the other phonological features which are present in the informal style which RA1 is heard using with colleagues occur less frequently when she interacts with patients, while some of them (e.g. /ʒ/ for /z/ and /ut/ for /aut/) are never used, even in response to patients whose speech includes these features. By including aspects of her vernacular style when she speaks

to patients across the front desk, RA1 constructs herself as a member of the same community, in a further contribution to her overall performance of the receptionist role as rapport-oriented and friendly (see §5.5.1, and §6.1.1). However, her front-desk style remains highly structured and formal in its choice of lexis, in the syntactic forms which are used and in the unhesitating enactment of the speech routines through which transactions are completed.

It has been mentioned that the style used by RA1 during telephone calls shows variation in the degree of formality, but it is impossible to work out if this is a form of communication accommodation (see Coupland 1984; Giles, Coupland and Coupland 1991) because the patient's contribution to the discourse is not heard. However, when RA1 speaks to patients at the front desk, the impact of the interlocutor can be assessed. This is briefly illustrated by the example in Extract 6.12. In a reminder that receptionists have backstage as well as frontstage roles and are managing more than one channel of communication at the same time (see Goffman 1969; Sarangi and Roberts 1999b; Hewitt 2003), the reception manager calls through to RA1 from the backstage area that she should not give patients appointments with Dr MacIntyre. This leads RA1 to tell the next patient, who has heard the reception manager's instruction, that this is exactly what she has just done. RA1 seems to consider the appointment mistake so exceptional that she wishes to share her reactions with the patient, who is implicated by his overhearing.

Extract 6.12

(Practice B, Disc 1, 44-32, M/26-40/lw/o)

1	RA1:	oh . I've just given one (.) too late (*PA20 laughs*) hi there
2	PA20:	gie you that first (*consent form*)
3	RA1:	I just gave one . there that minute (*PA20 laughs*) just . that .
4		minute . she was too late . (*laughs*) . you've got an appointment for

RA1 begins using a standard English present perfect form (line 1) but after hearing the Scottish variant 'gie' (line 2) from the patient, she reformulates her comment

using a dialectal grammatical structure herself (line 3), employing a past simple verb form, ‘gave’, although the adverb ‘just’ denotes perfect aspect. According to Communication Accommodation Theory (CAT), in doing this she is attuning her style to that of the patient, positioning herself closer to him by introducing in her own speech stylistic features which are more similar to his. The alignment is further effected by the reciprocal laughter and the co-use of the distal demonstrative ‘that’. Just as the patient puts distance between himself and the consent form by choosing this pronoun (line 2), the receptionist moves the perspective away from the immediacy of her response to her error, denoted in the first instance by the change-of-state marker ‘oh’ (line 1), towards a retrospective viewpoint by making two references to ‘that’ minute (line 3). During this incident RA1 has stepped temporarily out of role and, although continuing to discuss an institutional event, has done so within a different frame, that of an observer and commentator on her own actions. The accommodation of her speech style to that of the patient helps to involve him in this event and positions him as a joint observer. Although there are also sotto voce comments by receptionists about their backroom work, this is the only time that a backstage event impacts directly on receptionist-patient interaction. The incident thus also serves to demonstrate how little slippage there is between the two domains and how efficiently receptionists stay in role when dealing with patients.

There are also one or two occasions on which RA1 relaxes the formality of her style. We have already seen her face-saving comment ‘such a busy time eh . we’re forgetting’ (§6.1.2) but she also draws on popular idiom. For instance, on unexpectedly finding a repeat prescription, she exclaims ‘hit it lucky’ (Practice A, Disc 1, 61-24, F/61-75/lm/om), mixing the metaphors ‘hit the jackpot’ and ‘struck it lucky’ in a reference to the discourse of gaming. The expression is used to assess the situation as one in which a successful outcome was against the odds. In two other encounters RA1 uses the informal word ‘swap’ when handing out questionnaires and receiving consent forms, thus light-heartedly invoking the idea of exchange and barter as a face-saving device. In both these encounters RA1 goes beyond both her formal role and her shared Scottishness to display additional facets of her transportable identity.

Each of the five examples of the speech style of RA1 foregrounds a slightly different aspect of her identity. The casual style adopted during off-task conversations by RA1 and her colleagues is part of their shared membership of the surrounding speech community and their own small community of practice whereas, at the other end of the spectrum, the formal register used when the telephone is the channel of communication shows the receptionist playing her institutional role most fully. This formality is relaxed during face to face encounters with patients, as RA1 draws on her membership of the same speech community to build rapport-based, although still formal, relationships with them. In the turn by turn construction of encounters there are also signs of convergence towards the styles of patients, particularly when solidarity is at its strongest and goes beyond conventionalised rapport. There are also rare spontaneous moments in which a receptionist exploits her knowledge of non-institutional discourses to step outside the institutional frame and reveal something of her wider identity, by relaxing the formal style and drawing on popular idiom.

6.2.2 Co-construction of style

Each patient is heard only once, or very occasionally twice, in the data. As a result the speech styles of patients can only be compared with those of other patients. Comparisons have already been made of the performance of mainly un-contextualised items in service bids, greetings, apologies and forms of address by different patients. The contrasting construction of both patient and receptionist identities can be seen more clearly over extended stretches of talk, when like encounters are compared. This is illustrated in the following comparison of two encounters, one from Practice C (Practice C, Disc 1, 7-07, F/26-40/lw/om) and the other from Practice B (Practice B, Disc 3, 69-28, M/26-40/lw/esm). In both cases patients have forgotten the names of the doctors they are to see, which has an effect on the checking-in procedure. Although each encounter consists of three stages, Service Orientation, Information Check and Resolution, lasts for approximately the same length of time (60 seconds and 50 seconds) consists of many parallel moves, and involves both receptionists and patients in the same age groups (respectively 50-

60 and 26-40), the interactional styles are quite different. The contrasts are set out side by side in Table 6.4, in which similar actions are named in the left-hand column, which is left blank when different things are happening in the two encounters. Receptionist contributions are shaded and patient ones white.

Table 6.4: Comparison of identities in two encounters

Action	RC2 and PC3	RB4 and PB110
Service signal	*(eye contact)*	yes dear . can I help you?
Response token	hi .	yeah .
Appointment statement	I've got an appointment	I've got an appointment
Time statement	. er . at five to nine	for ten past three I think
Name statement	. my name's Joan Garry	--
Information check	and who's your appointment with?	what doctor?
Negative response	I've forgotten .	er . pass (.) dinnae ken
Remedy	I'm sorry .	I never . I never come here very often . once in a blue moon . so I dinnae even ken who my doctor is
Guess preface	it's . I think it's a male doctor if that	I think it's er […]
	male doctor (.) five to nine . Joan	can I give you that to (*questionnaire*)
Name guess	Wallace or?	I think it'a er:r Bijarnia I think
	(3) oh . it might be the locum today (2) no it's not (5) could I (1) what's your . er . date of birth ‖ please?	thanks dear . ta (*takes consent form*)
	‖ eleven five seventy-four	(4) am I male or female? . can you tell me?
		(2) hard to know
		(.) och . I'm in the sixteen to twenty-five category eh? (3) when did you visit? . Jesus . last year
	(11) it's with . er . (? it might be) eight fifty-five with the registrar (several words unclear)	okay? .
Receptionist resolution	. there we are . that's fine (2) would you like to see that lady (*research assistant*) first {PC3: mhm} over there . thank you	just have a seat
Acceptance		aye . nae bother .cheers

Both receptionists and patients in the two encounters have contrasting identities. This is apparent from the outset as RC2 gives an eye contact signal to perform the function of opening [40] whereas RB4 presents a hybrid style consisting of an elicitor/term of endearment combination, which suggests solidarity, and an offer, which suggests a service ethic. The responses of patients are also different. Patient C3 uses a rapport-marking greeting to confirm that a state of talk has been entered, whereas patient B110 follows the elicitor/offer opening with a positive response token, which, in turn construction terms, is an expectable next move after a question. Both patients then go on to state that they have appointments, using identical wording, and to give the time of the appointment, in both cases hedging their statements, PC3 with a filled pause and PB110 with the non-factive verb 'I think'. Following this, PC3 gives her name but PB110 does not. A small difference between the two patients is already apparent since PC3 gives all the information available to her whereas PB110 does not and the commitment of PB110 to the information in his time statement is also less than that of PC3 to the information in hers. The recordings also show that, while the two receptionists have similar Scottish accents, the accent of PB110 includes more distinctively Scottish features than that of either PC3 or the two receptionists.

The next moves of receptionists show a further divergence in their relational styles. Both seek the name of the doctor whom their patient is to see but RC2 uses a conventionally polite circumlocution 'and who's your appointment with', again manifesting the tendency towards a high level of formality which has already been mentioned (see §5.1.2 and Appendix 3, p.458), while RB4 is efficient and direct, asking 'what doctor', the use of 'what' rather than 'which' indexing a colloquial Scottish element in her style which was projected also by the socially marked use of 'dear'. In response to this, both patients produce a series of reactions consisting of an admission that they do not remember the doctor's name, a provision of remedy and further information about the doctor in the form of a name guess. While performing the same actions, they construct very different identities. PC3 takes up the formal style of RC2 with her information statement ('I've forgotten'), the conventionally

[40] The interpersonal content of this signal is not known because, as already mentioned, it cannot be determined from audio evidence.

polite apology ('I'm sorry') and truncated guess-preface ('I think it's a male doctor if that'), in which 'if that' seems to be the opening of the incomplete clause 'if that's any help', and the uncertain naming ('Wallace or ?'). In complete contrast, RB110 invokes the persona of a participant in a quiz programme who is unable to answer a question, 'pass', combining this with the direct answer, 'dinnae ken', which reciprocates the receptionist's directness and also indexes a working class Scottish identity. The same identity frame is developed during the patient's remedial action, an excuse in which he attributes his forgetting to infrequent attendance at the practice. As well as continuing in the vernacular style, revealed both by the phonological features of his speech and its grammar ('I never come here very often', 'I dinnae even ken who my doctor is'), the patient uses the colourful idiomatic expression 'once in a blue moon' (line 6).

Both patients appear to be cooperating as far as possible with the receptionists but, whereas PC3 shows "code consistency", which, according to Irvine (1979: 775), by maintaining formality, brings about "a greater display of respect for a traditional, normative social order", the use by PB110 both of intertextual reference (Kristeva 1986) to a quiz show and popular idiom, as well as his retention of a vernacular style, shows a lack of code consistency and gives the impression that he has brought along his non-institutional self. Both patients are using a form of linguistic capital but, whereas PC3 uses the legitimate, dominant language for this speech genre, PB110 draws on the symbolic capital available to him through membership of a solidarity-based working class culture, to some extent rejecting the current discourse field by using word play (see Bourdieu 1977b; Gal 1989; Woolard 1989). In both cases the signals given by receptionists are consistent with developments along these lines: RC2 provides a distant, non-verbal opening which is followed by a formal utterance whereas RB4 adopts a position which opens the way to informality and a more personal representation of self, together with PB110 'navigating' (Gafaranga 2001) between institutional identity and the transportable identities which are made relevant in the course of the interaction. The ongoing co-construction of the two encounters confirms these positions and also reveals more features of receptionist identities.

The remaining discourse at Practice C is entirely task-related. First the receptionist continues with her search for the appointment details on the computer, providing a description of what she is doing (from 'male doctor' to 'no it's not') and tentatively using a polite question to ask the patient for information which will assist her in her search ('what's your . er . date of birth please?'). After further commentary, she completes the task then indicates to the patient that she has done so with vaguely informing and evaluative comments ('there we are . that's fine') before pointing her in the direction of the research assistant who is dealing with consent forms and questionnaires. The patient makes no further contribution other than giving her date of birth and making a minimal acknowledgement of the final instruction.

At Practice B, in contrast, there is no further task talk until the receptionist implicitly signals that the appointment details are in order when she instructs the patient to take a seat. Instead, the receptionist gives the patient the research questionnaire, which he completes out loud, posing humorous rhetorical questions ('am I male or female? . can you tell me?', 'och . I'm in the sixteen to twenty-five category eh?') and making another expressive comment ('Jesus . last year'). The receptionist, who is completing her search for the appointment details silently, finds time to offer the patient the research questionnaire ('can I give you that to'), thank him in an informal style for the consent form ('thanks dear . ta'), share his humour ('hard to know') and check that the questionnaire has been successfully completed ('okay?'). The encounter ends with a further rapport-oriented turn from the patient, who answers the receptionist's question ('aye'), makes light of the imposition ('nae bother') and closes with a leavetaking token, all in a continuation of the informal style used throughout.

The four identities which emerge interactionally in these two encounters are all quite different. At Practice C the receptionist stays on task but, by vocalising the stages of her search for the doctor's name, makes a very open display of the difficulty she experiences when completing bureaucratic procedures, while the patient completes the discourse actions required by the task using a conventional, formal style. Together they co-construct a conventional enactment of the activity of checking in.

At Practice B, although RB4 opens with a double signal rather than relying on silent eye contact as does RC2, she otherwise uses only six words which contribute to the completion of the checking in task ('what doctor?' and 'just have a seat'), in contrast with the four utterances (15 words) connected with patient B110's completion of the research questionnaire. As a result she projects an identity which appears to be both efficient and friendly as well as responding out of role to the patient's non-institutional persona. The discourse performance of PB110 is typical for Practice B in its Scottish lexico-grammar but unusual on account of its intertextual reference and its idiomaticity. The patient cuts a distinctive figure for the context by making fuller expression of his transportable identity.

6.2.3 Lexical style

As we have seen, identities can be signalled by variations in phonology, grammar or lexis. Of these, lexical variation assumes salience in institutional contexts because of the specialist vocabularies which may be used (see §2.2.2). Both receptionists and patients sometimes signal their institutional competence, or foreground their institutional membership, through lexical choices. For example, the medication entitlement slips used by patients are mostly referred to, non-specifically, as prescriptions but, between themselves, receptionists always abbreviate this to 'scrips' or 'scripts' (observer notes). Receptionists at Practice A also use this in-group term three times when addressing patients, thus ascribing them the identity of experienced users of the system[41] (see §2.2.2). There is also one occasion on which a patient avails herself of this marker of insider knowledge but, although she shows her familiarity with the form, as shown in Extract 6.13 (lines 1, 6 and 10), she mispronounces the word, showing that her insider understanding is limited.

Extract 6.13

(Practice A, Disc 1, 39-50, F. No details.)

(*service orientation*)

1 PA16: I thought I had a || strip left

[41] Two of the patients so addressed completed questionnaires, which showed up a regular weekly attendance pattern for one and a monthly one for the other.

2 RA1: || is that

3 is that two items you're needing?

4 PA16: aha . aye . no so much (name of drug) . I've got enough

5 RA1: (.) fourteen nine forty-nine . that's you

6 PA16: that's it (1) I thought I had a strip left . I've got a funny feeling that when

7 || I've (several words unclear)

8 RA1: || such a busy time eh . we're forgetting things || these days

9 PA16: ||oh I know (1) I think I

10 must've thrown it out {RA1: aha} with the empty (.)strips

As a result of her error the patient unconsciously fails to attain the co-membership or communicative accommodation which, her lexical choice suggests, she is aiming for.

The Extract 6.13 encounter also shows how drugs are named when there is detailed discussion of prescription items (line 4). The name of the drug in this encounter is unclear, but elsewhere patients are heard using the trade or generic names of prescription items, as in Extract 6.14.

Extract 6.14

(Practice B, Disc 1, 65-52, M/41-60/lm/om)

1 RB2: (.) do you know what it is though? . na?

2 PB34: the Dihydrocodeine (2) e::m

3 RB2: (.) will I bring it up on the computer?

4 PB34: pardon?

5 RB2: will I bring it on the computer?

6 PB34: aye . please

7 RB2: (18) Simvastatin?

8 PB34: yep . Atenolol (2) and Aspirin (.) and the inhaler

9 RB2: Salbutomol (4) is that . everything you need? . that's everything you

10 usually get apart frae Fluoxetine

11 PB34: no . I'll forget that

Patient B4 remembers the names of three of the items on his prescription (lines 2, 8) but has to resort to a hesitation prompt ('e::m', line 2) and the use of a lay term, ('the

inhaler', line 8) for an additional two names which he has forgotten. A knowledge asymmetry emerges here because, with the help of the computer, the receptionist is able to fill in the missing names, (lines 7 and 9), as well as adding one more (line 10), using an information source not available to the patient. In using three product names, PB4 nevertheless shows some specialist competence, in contrast with the patients such as PA35 (see Extract 6.2), who are unable to remember the names of the drugs they are using[42]. PB4, that is, shows that he has attained a degree of institutional membership as a result of his knowledge whereas PA35 has not.

Institutional membership and its opposite are also visible in the referring expressions used to describe the content of appointments with practice nurses. For example, in a form of specialist shorthand, tests of different kinds are referred to metonymically by the names of their target physiology. Thus, backstage, receptionists refer to blood test as 'bloods' while, frontstage, two patients allude to cholesterol tests as 'cholesterol', as shown in Extract 6.15 (line 3).

Extract 6.15

(Practice A, Disc 1, 30-09, F/61-75/lm/esm)

1 RA1: hi there
2 PA14: hi . I've got an appointment with eh . eh . the nurse this morning for my
3 cholesterol (.)

A receptionist at Practice C makes a similar metonymic reference to a vaccination against influenza, 'the flu', (Extract 6.16, line 2), indexing a combination of familiarity and expert knowledge, as well as categorising the patient, who is being given an instruction, as a co-participant in this competence.

Extract 6.16

(Practice C, Disc 3, Track 2, 19-54, F/61-75/lm/om)

1 RC1: no . if I give you one of these . if you take off your jacket as well . it just

[42] It is to be noted, however, that neither receptionists nor patients mention the chemical or codenames of drugs, which might be used during case conferences to index co-membership of clinical teams (Cicourel 1992) but would be inappropriate in this context.

2 makes it easier when she gives you the flu

Vaccinations are mentioned seven times by participants, allowing comparison of terminology. Two patients refer to the procedure using the Scottish word ‘jag’ and one uses the colloquial English word ‘jabs’, while another talks about a ‘flu injection’, all four positioning themselves, either informally or formally, as lay persons with a non-specialist approach to the situation. A fifth patient avoids commitment to any form of naming, making a vague reference to ‘a flu thing’ (Extract 6.17 line 1).

Extract 6.17

(Practice C, Disc 2, 65-37, M/61-75/lm/ey)

1 PC66: can I make an appointment for a flu thing (.) || please
2 RC2: || for a flu vaccination?
3 PC66: mm
4 RC2: yes
5 RC2: (2) right . so (20) right . e::h . a::w (*hums a few notes*) (19) right

This is the only patient who is making an appointment for a vaccination, so the vagueness may be explained as a form of politeness which mitigates the request. Like the reformulation of the patient’s name which is described in Chapter 4 (§4.2.2), the receptionist’s restatement of the patient’s reference to the injection, using the more technical descriptor ‘flu vaccination’ (line 2), serves transactionally to confirm that the patient’s vague request has been correctly understood while simultaneously displaying the receptionist’s institutional competence.

6.2.4 Speech styles and discourse identity

Variations in speech styles, whether across encounters, participants or roles, reveal more than one aspect of speakers’ interpretations of the interaction. Receptionists clearly separate frontstage and backstage roles by switching to a more formal style while speaking to patients than they use when talking to immediate colleagues. However, variations in the formality of frontstage speech styles, both according to

the channel of communication and the amount of accommodation to the speech styles of patients, also suggest that individual receptionists differ in their interpretations of their roles. Different patients also foreground different aspects of their identities with styles on a continuum from strictly in-role contributions to those in which there is a drawing down of the symbolic capital available from transportable identities. At one end of the scale there are those patients who adhere to a routinised, conventional, style and at the other those who represent themselves as individuals with identities beyond their current roles. Stylistic modification can also be used to display institutional membership, competence or power but, like the use of forms of address, this resource is less freely accessible to patients than to receptionists.

6.3 Topic

Speakers can also change the discourse frame or bring other identities into play through changes of topic. There are five forms of talk in the data other than those required to complete the main front desk tasks. First, there is a group of task-related topics which are linked with everyday front desk activity. This includes supplementary observations (see also §6.1.2) and requests for additional information. Second, there are topics which are not directly related to the completion of front desk work: additional task talk, small talk and research talk. With the exception of comments about the research, which would not normally have been made, very few of these additional topics are introduced at Practice C, as shown in Table 6.5.

Table 6.5: Supplementary topics

Topic	Practice A		Practice B		Practice C		N
Task-related	**R**	**P**	**R**	**P**	**R**	**P**	
Instruction & observations	3	2	1	-	1	3	10
Information requests	-	2	-	1	-	2	5
Unrelated	**R**	**P**	**R**	**P**	**R**	**P**	
Additional task requests	-	-	-	1	1	3	5
Small talk	-	2	1	3	-	3	9
Research talk	2	11	2	18	2	3	38

R: receptionist, P: patient.

In the discussion which follows I consider the identity implications first of task-related topics and next of additional on and off-task requests. I then go on to consider the contribution of small talk to the construction of participant roles and, finally, I comment on research-related talk.

6.3.1 Task-related topics

In task-related comments, the transactional focus is maintained but there is a topic shift towards actions supplementary to those completed in the four routine stages (service orientation, information checking, confirmation and resolution). Comments can be either general observations, for example, 'hit it lucky', as already mentioned, from a receptionist, or 'save me coming back', which follows it from a patient, which indirectly conveys gratitude, or specific observations about actions, for example, 'hopefully he'll still see you' from a receptionist to a patient who is late for an appointment (Practice C, Disc 1, 68-13, M/16-25), which indirectly conveys censure, and 'got the right day today I hope' from a patient who seems to have memory problems (Practice C, Disc 2, 61-24, F/61-75/lm/om), which indirectly asks for tolerance. These topic extensions are all non-routine responses which do face-related work .

Two task-related comments will be considered in greater detail. In the first of these, which is shown in Extract 6.18, it is the patient who makes an additional comment to the receptionist (line 5).

Extract 6.18

(Practice A, Disc 3, Track 2, 01-49, M/61-75/lw/esm)

(*appointment bid is made*)

1 RA4: now you're looking at Tuesday the <u>seventh</u> (.) I don't have the
2 appointments that far ahead yet
3 PA58: so when do I come back?

4 RA4: e::rm (.) the end of this week . I've got the week pre:vious

5 PA58: well don't be putting anybody in front of me

The patient, who is unable to get the appointment he needs, gives the receptionist what is on the surface a very direct instruction (line 5). However, the felicity conditions (Searle 1969, 1979) are not met for this imperative to work as an order, since appointments which are not yet available cannot be reserved. It therefore has to be interpreted as a joke and, as such, is similar to the teasing of the research assistant by the same patient, for whom assertive banter appears to be an index of personal identity. This is therefore another illustration of drawing down by a patient of additional linguistic capital, in this case perhaps to index male dominance.

A change of frame can also be used to more positive ends, as Extract 6.19 shows. Receptionist B6, who at all times shows that she is sensitive to the relational as well as the transactional needs of patients, adds to the relational value of an encounter with one patient, who has been asked to make an appointment to have high blood pressure and a heart condition monitored, by giving a careful outline of the reasons for the double appointment which will be needed. In an extension of the transactional work normally done during front desk encounters, the receptionist explains both what will be done (line 2) and why the appointment will be longer than usual (lines 4-5).

Extract 6.19

(Practice B, Disc 3, 61-16, M/61-75/lm/om)

1 RB6: right (.) the one that you've got the letter about is a special clinic . you

2 ken . they're monitoring certain things

3 PB106: oh I see . yeah

(*gives appointment and checks patient details*)

4 RB6: (3) right . it's just that these are half an hour appointments cos (.) you'll

5 be getting tested

6 PB106: I see

7 RB6: and it takes a bit lo:nger

The comments seem to be designed to reassure the patient. This is suggested not only by the receptionist's explanation but also by the downtoning of the content through hedging, 'it's *just* that' (line 4); vague language, 'special clinic' (line 1), 'certain things' (line 2), which also maintains patient confidentiality, and 'a bit longer' (line 7); the sharing of the perspective of the patient, 'you ken' (lines 1-2) and 'you'll be getting tested' (lines 4-5); and the use of a casual speech style, 'you ken' (lines 1-2), 'cos' (line 4). Furthermore, although this is not shown in the transcript, the receptionist lowered and softened her voice when explanations were being given. This therefore seems to be an example of discursive hybridity (see §2.2.1), since the receptionist forsakes the conventional bureaucratic format and appropriates a style which is more closely associated with therapeutic discourse (see §2.2.1 and §2.4.3). By introducing a topic which is atypical and presenting it in a style which is also atypical, the receptionist uses this additional style as a form of symbolic capital to add another dimension to the performance of her institutional role, bringing herself closer to the clinical staff whose work she helps to organise.

6.3.2 Additional requests and task talk

Patients make five requests for additional information which are related to the standard task-content of encounters and four which involve other tasks. Most of the requests related to standard tasks concern clinical staff: whether a doctor is running late, whether a doctor has a student or researcher observing him, whether a doctor is a 'lady', the number to call to speak to a practice physiotherapist. The small number of these requests in itself suggests that seeking additional information about the current situation is not an essential part of the role of 'doing being' a patient at the front desk but the fifth request (Extract 6.20) tells us something about the information which front desk expertise does entail.

Extract 6.20

(Practice C, Disc 1, 68-13, M/16-25/new patient)

(*patient checks in*)

1 PC39: em . I was wondering . what I should do . I was wondering what the: er
2 . situation for students
3 RC4: (1) sorry?
4 PC39: what's the fee situation for students . || is it
5 RC4: || well . there <u>is</u> no charge to see the
6 doctor

This young patient, who is identified by his accent as from the Republic of Ireland, is evidently not aware that free NHS medical care is available to citizens of the European Union who are in the UK and asks if he is to pay a fee, first vaguely with the word 'situation' (line 2) and then, when the receptionist does not understand and so initiates repair (line 3), explicitly (line 4). As in other situations for which there is only one example in the data, this one case of ignorance of the rules brings into relief the procedural competence of other patients. Unlike the other four requests for task-related information which, apart from the query about the physiotherapist's number, ask for non-essential supplementary detail, this one reveals that the patient has an inadequate understanding of how to play his role.

Three of the four additional task requests are the result of practice attendance and include enquiries about a bus pass and a walking stick left in consulting rooms and a request to have a taxi ordered. The fourth, more unusual, enquiry is also made by the patient who asked the question about fees. This time though, as shown in Extract 6.21, he asks a receptionist how to make a telephone call.

Extract 6.21

(Practice C, Disc 2, 23-00, M/16-25)

1 PC39: excuse me
2 RC2: yes
3 PC39: I received this number here . and I was wondering . is there a code to go
4 with it? (.) it's not ringing properly
5 RC2: yes . well . if it's in Scotsville you'll automatically do 0123
6 {PC39: oh} first before your number .

7 PC39: okay . alright
8 RC2: if you're using your mobile
9 PC39: what was that . 01
10 RC2: 23
11 PC39: 23. okay then
12 RC2: and then your number . okay? . any number that you're phoning in
13 Scotsville . you've got to do the code first . if you're using your mobile
14 PC39: okay . thank you
15 RC2: alright? . by:e

It seems that patient C39's contribution is allowable, since the receptionist responds to it rather than refusing to help, but it does go beyond the norm for the situation and may not have been made by a patient more familiar with front desk conventions. And, of course, this is not the only example of a telephone-related matter stimulating off-task talk: as was shown in Chapter 4 (§4.6), proceedings were also interrupted when a receptionist's mobile phone rang unexpectedly.

6.3.3 Small talk

In lay terms, as McCarthy (2003: 33) points out, small talk is "talk that is in some sense an "extra" to the business at hand". Thus, McCarthy and other contributors to Coupland's (2000) edited volume on small talk, discuss a range of talk types, from brief phatic exchanges to personal anecdotes to evaluative comments, some of which have been mentioned already. The talk considered in this section is primarily of the type termed 'overlay talk' by Kuiper and Flindall (2000: 192). It takes place during the completion of transactions but it is purely relational in content and covers personal or situational topics which are not connected with the business in hand.

There are nine examples in the data either of personal comments or the discussion of personal matters, all except one of them introduced by patients. Patients' contributions include two comments on the coincidence of medical events with personal celebrations, 'my wedding anniversary' (Practice A, Disc 3, 54-16, F/41-

60/lm/om) and 'that's his birthday' (Practice C, Disc 1, 28-20, F/ No details), two comments on personal experience, 'got a full appointment diary you see' (Practice B, Disc 1, 03-09, M/61-75/lm/o) and 'for a while it [attendance at the practice] was every bloody week nearly eh?' (Practice B, Disc 1, 57-13, F/41-60/lm/esm), one of the three examples of a solidarity-based use of expletives in the data (see Daly et al. 2004), and two enquiries after receptionists' personal well-being, 'there's Tina - how are you?' (Practice B, Disc 3, 13-58, M & W/61-75/ly/ey) and 'are you okay dear?' (Practice C, Disc 2, 65-37, M/61-75/lm/ey). There is also what seems to be one comment on the weather, '(?och it's cold out)' (Practice A, Disc 3, Track 3, 51-55, F/41-60/lw/om) and one on the doctor, 'seems to be awfully popular' (Practice C, Disc 1, 64-53, M. No details).

Most of this talk is confined to single comments which are not developed by receptionists. Not even the patient request about a receptionist's personal well-being, 'are you okay dear', is taken up, although this may be because the receptionist, one of two at the desk, does not hear it. An example of a receptionist ignoring additional comments is shown in Extract 6.22.

Extract 6.22

(Practice C, Disc 1, 64-53, M. No details.)

(*research forms are dealt with*)

1 RC1: and you'r:e . wanting to make an appointment (.) or you have one?
2 PC35: no . I'd like to make one please . with Dr Nash
3 RC1: aha
4 PC35: I'd better get my diary out {RC1: aha} see how it works out (5)
5 || not sure what I've done with it
6 RC1: || his first appointment wouldn't be till the sixth of November
7 PC35: I- . I thought it'd be something like that (3) thought I had my diary with
8 me (2) oh well . it should be okay . sixth of November then

(*appointment made and patient information checked*)

9 P35 so that's the sixth of November
10 RC1: (1) at five twenty

11 PC35: at five twenty pippemmo (*p.m.)*

12 RC1: (.) with Dr Nash

13 PC35: okey dokes (.) right .seems to be awfully popular

14 RC1: yes he is . and he's on annual leave as well

As well as indexing his personal identity by using lexical items which are unique in the data ('pippemmo', 'okey-dokes' and 'awfully', lines 11-12), the patient in Extract 6.22 introduces more than one supplementary topic. The receptionist treats the task-related comments about his diary (lines 4-5, 7-8) as self-directed, responding only as far as is necessary for an appointment to be made but she does react to his hedged assessment of the doctor (line 13). She does this through two moves (line 14). First there is an agreement with the patient's assessment and then a remark in which she treats the comment about the doctor's popularity as a matter which contributes to the difficulty of getting an appointment with him. By orienting to the comment in this way rather than, for example, encouraging discussion of reasons for the doctor's popularity, she ensures that the discourse perspective remains task-related and thus holds to her institutional role.

In complete contrast, the off-task topic through which a patient projects a non-institutional frame in Extract 6.23 (lines 4-5) is taken up and developed by the receptionist (line 6).

Extract 6.23

(Practice B, Disc 2, 03-09, M/61-75/lm/o)

(*appointment given and patient details taken*)

1 RB3: (.) will I write it down for you? or

2 PB27: please . if you don't mind

3 RB3: yep

4 PB27: (3) got a full appointment diary you see and you've got to keep it

5 || up to date

6 RB3: || ha ha aye || got a busy. busy life style

7 PB27: || ha ha . what you laughing at?

8 RB3: ha ha ha ha ha

In this extract the receptionist goes further than simply acknowledging the comment: she also extends it, reciprocates its tone and shares laughter with the patient. Boxer and Cortes-Conde (1997) point out that, while teasing and joking about others has a primarily relational function, joking about oneself is a means of displaying one's own identity. Following this interpretation, the patient here is seen displaying a flirtatious masculine identity which the receptionist accepts by providing relational support (see also Norrick 1993; Kotthoff 1996). In addition, as Holmes and Stubbe (2003: 109-110) point out, "[h]umour typically constructs participants as equals, emphasising what they have in common and playing down power differences". By changing topic and shifting from an institutional to a personal discourse frame and footing, this patient also brings his distal identity into the discourse while, by responding, the receptionist acknowledges and accepts it.

There is also one exceptional episode of personal talk (Extract 6.24) which is introduced by a patient.

Extract 6.24

(Practice B, Disc 3, 13-58, M & F/61-75/ly/ey)

(*PB79H checks in on behalf of his wife, who is in a wheelchair*)

1 PB79: there's Tina

2 PB79H: there she's there

3 RB4: hi Margaret! hello:! . how are <u>you</u>?

4 P79: no bad (.) I- . I- . I thought you didnae see me when I come in

5 RB4: no I didnae . I was: chatting and (unclear word) with that man . aye

6 P79: (inaudible)

7 RB4: aha . ha ha ha ha ha: . ha

8 P79: hee hee hee

9 RB4: you still got your sense of humour || anyway .

10 P79: || a . hee hee hee

11 RB4: I can tell you || ha ha ha

12 P79: ||hee hee hee

13 PB79H: (inaudible)
14 RB4: are you alright?
15 PB79H: lots of bother (?with her)
16 RB4: ha ha ha
17 P79: heh heh heh heh heh heh
18 RB4: ha (inbreath) a: || :h
19 P79: || and . how's your knee?
[…]
20 RB4: och . alright || the one th- . the one that
21 PB79H: ||what are you asking me if I'm alright for?
22 RB4: I just thought I'd ask you because . you know . I asked . I asked Margaret so
23 I've had to ask you didn't I?
24 (*continues*)

The encounter opens with the reciprocal use of first names and a token of 'how are you?' (lines 1-3) and continues with one of only two references to participants' health in the data[43], accompanied by teasing comments and mutual laughter, uttered in a high involvement style marked by a great deal of overlapping talk (see Tannen 1984). In this encounter it is clear that the receptionist and the patient, who is accompanied by her husband (PB79H), know each other well[44] and this seems to explain the non-normative style and content of the talk. For this reason it cannot be regarded as typical of front desk talk since none of the three participants is occupying an institutional role. However, the small talk which develops in Extract 6.25 is between speakers who do not know each other well since, prior to the passage which is shown, the receptionist has asked the patient for her name. The small talk seems to be occasioned by an unusual event: the arrival at the practice of toddler triplets who have adult twin siblings.

Extract 6.25

(Practice B, Disc 3, 37-14, F/41-60/lw/om)

(*service offer and bid are made*)

1 RB6: (2) hello girls

[43] The other is a reference to the side-effects of her arthritis by a patient at Practice A (A3, 52-59).
[44] It is not known if this is from repeated contact at the practice or because of social contact elsewhere.

2 PB90: e:h . last week
3 RB6: have you been good girls?
4 PB90: e:h
5 RB6: for your mum?
6 PB90: (1) the three lassies? . no
7 RB6: (.) no?
8 PB90: nah || they do nothing but fight
(*RB6 speaks to HH about the triplets*)
9 RB6: yeah . it must be easier now though
10 PB90: I think if I'd had two lassies and one laddie maybe (.) it's just cos it's
11 three lassies . they just fight . over the least wee thing (.) constant (.)
12 || constant
13 RB6: || maybe it's cos they're the same age
14 PB90: I think so . I think so . cos I mean . I had the twins eh . and they're no
15 twenty-five: and I mean a laddie and a lassie . you ken what I mean . so: . I
16 had problems with them . but no as bad as that . oh na
17 RB6: (.) you know what women are like
18 HH: (.) next time it'll be four
19 PB90: oh no . no way {HH: hh hh ha ha} no . I'm not going through all that
20 again . no way . ha ha ha
21 RB6: aye . you could have four Alison . that would be nice
22 PB90: no . dinnae . that's what my father says . he says you've had
23 RB6: I wond-
24 PB90: he says 'you had S' . he says 'then you had two. he says 'now you've got
25 three . when's the four?' . and I've went 'forget it . no way'
26 RB6: that would be nice (1) we've not got four
27 PB90: (.) my grey hairs are coming quick . fast and furious
28 RB6: haha ha haha
29 PB90: I'll be white-headed
30 RB6: ha ha ha ha ha

The receptionist, RB6, leads the topic development with rhetorical questions (lines 3, 5) addressed to the babies who cannot yet talk but directed towards their mother. She goes on to stimulate talk from the mother through echo questions (line 7) and topic continuers (lines 9, 13, 17, 21, 26) and to align herself with her both through

supportive topic continuers (e.g. 'you know what women are like', line 17) and affiliative laughter (lines 28 and 30). In the patient's self-disclosure and the responsive support which is given by the receptionist, the sequence is characteristic of women's talk as observed, for example, by Coates (1996) but it is also another example of talk which approximates to the therapeutic discourse of counselling, since the receptionist creates an opportunity for the patient to air her problems and engages in sympathetic listening. This is the same receptionist who we have already seen providing support to a patient facing a difficult examination (§6.3.1). Here too she finds an opportunity to broaden the scope of her role and, in so doing, to reveal more of her own identity.

6.3.4 Research-related small talk

Thirty eight comments were made about the research, 84% of them from patients. The types of comment made were sometimes transactional and sometimes relational in content. Transactional comments included requests for additional background information, requests for help with completion of questionnaires, either on account of doubt about how exactly questions should be answered or because of poor eyesight, and expressions of anxiety that completion of the questionnaire would occupy too much time. Relational topics included affirmation of confidence in receptionists and, from several men in the 61-75 and 75+ age brackets, the use of the questionnaire as a pretext for topic expansion and flirtation with receptionists, as illustrated in Extract 6.26.

Extract 6.26

(Practice B, Disc 2, Track 1, 12-22, M/61-75/lm/om)

1 PB61: this is all your fault is it?
2 RB1: aye || yes . I'm afraid so (.) ha
3 PB61: || ha ha ha ha ha

The impression was given that this unusual event provided an alternative frame space (see §2.2.2) which created an opportunity for patients to draw receptionists out of

role in a manner which was not normally available to them (see also §4.6). Like RB1 in the example, receptionists responded politely to comments of this type but did not encourage discussion of the research, nor did they instigate research-based relational talk themselves[45]. In other words, the research became an occasion for additional identity display by patients whereas receptionists treated it as an additional duty.

6.3.5 Topic and discourse identities

With the exception of the talk brought about by the research, there is very little digression from the topics required to enable completion of the main front desk activity types. Additional topics are sometimes introduced to perform tasks associated with face maintenance for self and other. A very small number of patients seek additional, non-essential, information about practice services, while another small group introduce tasks which are a spin-off from their practice attendance. There are two exceptional requests but these are both made by a patient who is unfamiliar with the culture of the NHS.

In contrast with service encounters in many other settings (see Coupland 2000), and encounters specifically with receptionists (see Schneider 1988, 1989; Hewitt 2001b), receptionists and patients at the front desks of the three practices where data were collected construct very little overlay talk. Also, in contrast with commercial service encounters, where small talk is almost always elicited by the server and covers topics such as the future plans of customers, a restricted number of topics is introduced and almost always by patients. However, when there is talk on additional topics by receptionists, it enhances their performance of front desk activities while allowing them at the same time to make greater expression of identities which are suppressed when a narrow interpretation is made of the role. Furthermore, the use of the research by patients as a pretext for small talk suggests that they would respond favourably to an increase both in the range of topics introduced and the quantity of relational talk at the front desk.

[45] See also Chapter 8, section 8.3.1

6.4 Conclusions

The analysis of person reference, speech styles and supplementary topics has revealed the presence of a variety of speaker positions and attitudes. Receptionists mark their occupancy of the front-desk role by increasing the formality of their speech styles or using less colloquial language, more so, in the case of at least one receptionist, when the channel of communication is the telephone than when they are face-to-face with patients. However, receptionists vary in their understanding of the degree of formality and distance which is appropriate in front desk talk. Some favour 'impersonalness' (Gudykunst and Kim 1997: 106, cited in Placencia 2004:217), and show a "tendency to respond to specific aspects (i.e. the role) of another person", whereas others lean towards 'personalness', and are inclined to "respond to others as total persons". They are abetted in this by patients, who also display differing degrees of impersonalness and personalness. While some patients occupy formal positions, remaining in role within their 'situated' identities and limiting the range of their discourse, others draw on the symbolic capital available to them from their wider, 'transportable' identities and thereby construct both themselves and their interlocutors as persons with identities beyond the current role (see Zimmerman 1998).

When speakers adhere closely to linguistic norms they are re-enacting the existing social structures more closely than when these norms are stretched or challenged (Fairclough 1989, 1992, 1995). Participants in the front desk encounters in these data appear to replicate existing norms more frequently than they challenge them. There is little digression from the stages and moves which define all front desk activity types as sub-categories of the same genre. Furthermore, patients are not given much opportunity, nor do receptionists often choose, to draw on the full range of linguistic capital available to them. As a result, the voice of the lifeworld is heard less frequently than that of strategic bureaucratic discourse (see §2.2.3, §2.4.2 and §2.4.3). However, front desk talk can become more expansive and normative front desk discourses can be amplified and adapted. This was seen in encounters in which

receptionists responded to and facilitated patients' expressions of non-institutional selves, in the few out-of-frame comments made by receptionists and in the inter-discursive practice of receptionist B6, who used both expository talk and small talk to support patients.

Hanks (1990) suggests that shared knowledge is symmetric and separating knowledge asymmetric. Patients, particularly the more experienced or expert ones, may share part of the receptionist's knowledge of the front desk 'frame of reference' (Schutz 1970: 74 ff., cited in Hanks 1990: 71) but it is apparent, from features such as receptionists' access to privileged inside information (for example, names of patients, number of appointments available) and their knowledge of the bureaucratic obligations associated with their role, that there is a knowledge asymmetry in their favour. Sometimes receptionists make a display of the authority which this asymmetry gives them, for example when they make use of the power of naming, particularly first names or terms of endearment, which imply a rank disparity in their favour; when they use first person pronouns during decision-making about appointments; when they close down off-task topics introduced by patients; or when they reformulate patients' utterances using more formal or specialist terminology. However, it is also possible for them to mitigate the imbalance by showing respect or deference for patients in naming practices, by aligning themselves with patients through accommodation to their speech styles or the display of their own wider identities in the talk, or to disguise their authority by concealing the degree of agency available to them in appointment making and using lay rather than specialist terms.

Receptionists are often under pressure and it would be inappropriate for them to spend too much time in off-task talk or the expression of self, but immersion in the role which, if carried to extremes, can become the denial of selfhood (see Cameron 2000), need not be complete. The use of popular idiom, the sharing of patient humour and the expansion of the front desk discursive repertoire all show that it is open to receptionists to make a broader interpretation of the role, and to construct a more multi-facetted version of self while at the same time improving the service

offered to patients. In Chapter 7 three contrasting presentations of self in problem-solving encounters will be examined in detail.

Chapter 7

Three problem-solving encounters

7.0 Introduction

There are a number of reasons for the close analysis of three problem-solving encounters which is provided in this chapter. First, the detailed attention to a small number of encounters, one from each practice, is designed to complement the more wide-ranging quantitative and qualitative discussion in the preceding chapters. Second, problem-solving encounters tend to last longer and provide an opportunity to observe the unfolding of participant identities and, third, problem-solving encounters, while retaining routine elements, are more varied than other activity types, because of the uniqueness of the problems being dealt with. Since they represent an increased challenge to both the transactional and relational competence of the receptionist, problem-solving encounters thus both instantiate the general discourse patterns which have been observed and provide new insights into participants' construction and understanding of the interaction.

There are fourteen examples in the data of problems arising because mistakes have been made either by patients, doctors, receptionists or pharmacists[46]. Three repeat prescription slips were missing, all for reasons which were unclear. Four repeat prescription orders were submitted at the last minute: that is, patients hoped to obtain the prescriptions immediately rather than after the two-day interval specified by all three practices as the time necessary for a repeat prescription to be issued. Four prescriptions were incomplete because of errors by doctors and one was wrongly dispensed because the details of the order were not clearly marked. Finally, as Table 7.1 shows, one practice lost a test sample and, at the same practice, one receptionist failed to log the time of a patient's appointment into the computer.

[46] There were also three occasions on which problems arose because of uncertainty about procedures but only problems which arose because of mistakes or misunderstandings will be considered here.

Table 7.1: Responsibility for problems

Problem	Practice A	Practice B	Practice C
Patient responsible			
Prescription reordered late	2	1	1
Prescription order unclear	1	-	-
Practice responsible			
Prescription inaccurate	2	-	2
Test sample lost	-	-	1
Appointment not logged	-	-	1
Responsibility unclear			
Prescription lost	-	2	1
TOTAL	5	3	6

Problem-solving encounters follow the canonical structure for front desk encounters and include Service Orientation, Information Check, Confirmation and Resolution stages. However, as shown in Chapter 4, Service Orientation and Information Check stages tend to be longer and more recursive than during other front desk activities, there are fewer Confirmation sequences and, as in appointment-making encounters, more than one Resolution proposal may be offered before a successful conclusion is reached. Two types of interactional work are involved in the solving of problems: the presentation of the problem and its solution. In the present data the existence of a problem sometimes emerged in the course of an encounter; while at other times the problem was explained by the patient during the service bid. Patients described problems in a number of ways. In addition to providing the necessary information three patients included self-evaluation and one an evaluation of the patient whom she was representing. The remainder also included additional personal information, ranging in quantity from single comments to mini-narratives. The approaches did not appear to correlate closely with either problem types or causes but seemed to be the result of variables such as the identities of both receptionist and patient and the development of the interaction[47].

[47] There is no table for problem presentation, which was too complex for representation in this simplified form.

Solutions were provided for all problems but, as Table 7.2 shows, acceptance of responsibility for a mistake did not always lead to an apology.

Table 7.2: Acceptance of responsibility

Problem	Practice A	Practice B	Practice C
Patient mistake			
Prescription reordered late	P accepted (2)	P accepted (1)	P accepted (1)
Prescription order unclear	no admission (1)	-	-
Practice mistake			
Prescription inaccurate	doctor responsible (2)	-	doctor responsible (1) no admission (1)
Test sample lost	-	-	no admission (1)
Appointment not logged	-	-	R apology (1)
Responsibility unclear			
Prescription lost	-	R apology (1) no admission (1)	no admission (1)
TOTAL	5	3	6

P: patient; R: receptionist

There were two apologies, both from receptionists. Receptionists also three times attributed factual errors in prescriptions to doctors while patients always accepted responsibility for emergency submission of prescription requests but did not apologise. There were also two problems for which neither receptionist nor patient admitted responsibility and three encounters in which not all the details were known, because recordings ended before problems had been fully resolved.

As already mentioned, one problem-solving encounter from each practice has been selected for detailed analysis. From Practice A there is an encounter in which a repeat prescription order is wrong because of a doctor's mistake; from Practice B an encounter in which a repeat prescription order is missing for reasons which are obscure and, from Practice C, an encounter in which a receptionist does not log the details of an emergency appointment into the computer. The examples do not cover every permutation in problem-solving encounters but have been selected to illustrate the types of position which are adopted by receptionists and patients and to show how these are developed in the course of the interaction.

7.1 Tramadol: A missing prescription item

In the first example an item is missing from the patient's repeat prescription list as a result of a doctor's error (see also §6.1.1, Extract 6.3). The encounter begins with an exchange of consent form and questionnaire together with a small amount of associated discussion and the patient then goes on to make his service bid.

Extract 7.1

(Practice A, Disc 2, Track 2, 04-09, M/41-60/lm/om)

PA35: I've been getting this prescription (.) for . for a while {RA2: aha} and I got a: . a tablet added on just (.) about two month ago {RA2: mhm} and when I was looking at it and there was only three items on it and there should've been four

RA2: well I need to get a doctor to do it. so what is the name of the tablet?`

The explanation of the problem is presented in the form of a short first-person narrative (see Labov and Waletzky 1967), which includes an 'orientation', 'I've been getting this prescription (.) for . for a while', and a 'complicating action', which begins with and 'I got a: . a tablet' and continues until the end of the patient's turn. PA35 has a hesitant delivery, marked by two pauses and two self-repairs, the second of which is prolonged ('for . for', 'a: . a'), and a speech style which is both informal ('tablet' 'should've been') and shows local dialect features ('two month', 'there was'). In addition, the narrative is constructed through a series of verbs in which there is alternation between present and past time, perfect, progressive and simple aspects and active and passive voices (I've been getting', 'I got [..] added on', 'I was looking', 'there was', 'there should've been'). The first two of these verbs are also reinforced by complementary time adverbials ('for a while', 'about two month ago').

Narratives are presentations of self which have both an interpersonal and a transactional role and are related at the same time to "the participation framework of the moment and current social projects" (Goodwin 1997: 107). Thus, as Schegloff (1997a: 97) points out "[r]ecipients are oriented not only to the story as a discursive unit, but to what is being done by it, with it, through it". Cook-Gumperz and

Gumperz (1997) have noted that narratives are used strategically as a resource for doing bureaucratic explanation in face-to-face interviews while, according to Martin and Plum (1997: 301), they "negotiate solidarity by offering an affectual response to an extraordinary event for the listener […] to share", creating, as Schiffrin (1990: 253) points out, "a widened base of support for [a] position".

Following these criteria it appears that, rather than making a simple factual statement of the problem, PA35 pursues his current project (of obtaining the missing prescription item) by 'negotiating solidarity' and offering 'a widened base of support' for his case. His informal, colloquial style constructs a 'lay', rather than an institutionally proficient, persona, a position which is also indexed by the hesitancy of the story telling and the use of the passive voice with reference only to the problematic prescription item. PA35 never explicitly states that he wishes to have the missing item replaced but lets his narrative indirectly do the work for him, linking present time with the past narrative time of his personal experience through temporal and aspectual variation (see Briggs 1996). This indirectness minimises the imposition which is being made on the receptionist but at the same time reduces the patient's personal agency.

In her response (line 5), as predicted by Schegloff's understanding of the function of narrative, RA2 orients to the transactional rather than the relational content of the patient's talk. She has already maintained her place in the dialogue with the two continuers 'aha' and 'mhm' (Schegloff 1981; Gardner 2001) and now immediately passes responsibility for the problem to the doctor. She prefaces her statement with the discourse marker 'well', which can be used "wherever the coherence options of one component of talk differ from those of another" (Schiffrin 1987: 127) and consequently often precedes dispreferred actions such as the non-compliance with a request which occurs here (see also Owen 1983). The use of a first person pronoun as she describes her own lack of agency in prescription matters links RA2 with PA35 but the time shift to the present ('I need') emphasises the contrast between them. In the second part of the turn, in which the present time reference is continued, RA2 begins an Information Check. This is introduced by the discourse marker 'so', which

signals a return to the main topic (Schiffrin 1987). Here it seems to carry an implication that, by not mentioning the name of the missing item, PA35 has failed to contribute appropriately to topic development.

Whereas PA35 used a personal experience frame, RA2 uses an institutional one. Jefferson and Lee (1992: 535), who refer to the interest of institutional personnel in problems rather than people as the "cargo syndrome"[48], point out that "while in a troubles-telling the focal object is the 'teller and his experiences', in the service encounter, the focal object is the 'problem and its properties'". Instead of showing sympathy for PA35, or following his story with a parallel anecdote of her own, as might have happened in everyday conversation, RA2 observes the norms for her institutional role (see Sacks 1992, cited in Schegloff 1997a: 104). However, as she passes the floor back to PA35 with her question 'so what is the name of the tablet?`, RA2 does show some alignment with him by using the same referent as he has, 'tablet', to refer to the missing item. This legitimises the return to a lay perspective as PA35 accounts for his non-provision of the name.

6	PA35:	pet . I can't remember (2) I'm no a good reader . I just taen them you
7		know (.) I was looking for the box this morning (1) I noticed it was
8		(?missing) but I'm no a very good reader . so it- I couldnae remember the
9		name of them (*sniffs, sighs*) (4) so it's just the new one that's just been
10		‖ two months . yeah
11	RA2:	‖ I'll just check your record (.) hold on a minute (*phone starts ringing*) (6)
12		Tramadol (3) Tramadol it's called
13	PA35:	yeah . aye (*laughs*)
14	RA2:	no but if I say that (.) you can remember if anybody asks . it's Tramadol (2)
15		there we ↑go . that be Wednesday . is that okay?
16	PA35:	yeah yeah
17	RA2:	in the afternoon

The turn-initial use of the term of endearment, 'pet', keys the return to a personal experience frame. PA35 goes on to account for his inability to give the name of the

[48] Because of observation that the desk staff in emergency call centres treat patients in ambulances as cargo rather than identified individuals.

medicine with a double excuse, 'I can't remember (2) I'm no a good reader', (Scott and Lyman 1981, see also §5.3), reformulated later as 'I'm no a very good reader . so it- I couldnae remember the name of them', continuing to represent himself as incompetent and inexpert. This negative self-evaluation is embedded in a continuation of the hesitant narrative account which began in his earlier turn. Although he begins with present time reference, PA35 then produces another series of past tense verbs, as well as alternation between simple and progressive aspects ('I just taen them you know (.) I was looking for the box this morning (1) I noticed it was (?missing)'. By referring to the missing tablets in the plural and mentioning the box in which his prescription has been packaged, PA35 constructs them as real items rather than the generic type 'the tablet', which has been presented by RA2. In addition, furthering the rapport-orientation implied by the vocative 'pet', PA35 uses the presentation marker 'you know' (Jucker and Smith 1998), which has been interpreted as appealing for both understanding and solidarity (Holmes 1986; Fraser 1990), retains a vernacular speech style ('I'm no', 'I just taen them', I couldnae') and repeats 'just' in the formulation which closes his turn (lines 5-6), giving himself additional face protection by minimising the prospective imposition (Aijmer 1985, 2002).

In her next response, RA2 claims the floor before PA35 has completed his turn, softening the interruption by echoing the downgrading use of 'just' by PA35 himself and sustaining solidarity by telling PA35 what she will do next (lines 11-12). Whereas the patient describes the absence of the prescription item in terms which are physical and experiential, for the receptionist a medical "intertextual chain" (Fairclough 1992: 130) has transformed the outcome of the patient's original consultation into a computer record. The next action of RA2 is therefore to look for the name of the item on the front desk computer (line 8). Before doing this, she instructs PA35 to 'hold on a minute', using a 'bald on record' imperative form, which suggests that she feels entitled to issue the instruction rather than regarding it as a matter which requires remedy (see Lindström 2005). In addition, RA2 appears to accept the view of self which PA35 has projected and, giving him priority over the ringing telephone, embarks on an instructional sequence (lines 12 and 14).

During *ad hoc* teaching sequences of this type, the 'teacher' is in a hierarchical position in relation to the 'recipient' who, other than acknowledging the instruction, remains passive (Kepler and Luckmann 1991). These are the positions of RA2 and PA35: PA35 gives only acknowledgment (line 13) while RA2 makes an open display of her knowledge, three times emphatically repeating the name of the missing drug, 'Tramadol', before reinforcing her 'entitlement to teach' (Kepler and Luckmann op. cit.) with a conditional construction in which she justifies the 'teaching' ('no but if I say that (.) you can remember if anybody asks'). Although RA2 deals with the problem efficiently and quickly, in line with the tendency in doctor-patient consultations (Fisher and Groce 1990), she makes no apology to PA35 for the doctor's error. Instead, she places emphasis on his own memory lapse, highlighting his lack of competence in this area. Thus, although RA2 presents the instructional sequence as useful for PA35, the effect of her intervention is to highlight the asymmetry between them.

RA2 completes the transactional business (line 15) by informing PA35 about the resolution of the problem and checking that it is acceptable to him. Again, as she prepares to offer the floor to PA35, RA2 realigns herself with him, both in the routinely phatic summing up clause, 'there *we* go', and the informal 'that be Wednesday', which is attuned to his vernacular speech style. In the aftermath of his failure to provide information, PA35 makes no further contribution to the completion of the task other than accepting the receptionist's actions with the positive, although relationally neutral response tokens 'yeah' and 'aye' (lines 13 and 16) (see McCarthy 2003). However, there is a short coda in which PA35 checks with RA2 that he has dealt with the questionnaire correctly and she, continuing in a style which is facilitative but, at the same time, constructs PA35 as lacking in full competence, offers to complete the process for him (line 21).

18 PA35: (2) is . is that it then?
19 RA2: that's it . if you just (.) put it (*questionnaire*) in the box . thank you
20 PA35: thanks very much
21 RA2: okay . do you want me to do it for you?

22 PA35: thanks

23 RA2: okay . no problem

It may be that, in this encounter, the role-based asymmetry is a matter of routine, since there are a number of points which indicate that RA2 and PA35 already know one another. PA35 attends the practice once a month, RA2 does not ask for his name and there is definite reference to two items which are receiving their first mention, 'the tablet' (line 1) and 'the box' (line 3), which suggests that there is common ground between the speakers (Clark 1996). However, it may also be that this was an integral feature of the interpretation of her role by RA2, the reception manager, since she adopted a position of authority towards anyone, including doctors, who came into the reception area. Her attitude is well summed up by a comment she made, when the practice phlebotomist reported to her that a patient had been smoking in the waiting room: 'I wished I had seen or I woulda told him off'. RA2 appears to assume that she has the authority to exercise control over all who are present in the area for which she is responsible.

PA35 did not resist the authoritarian stance of RA2. On the contrary, he appeared to collaborate with her in the construction of asymmetrical positions. It is impossible to say whether the positioning of PA35 was strategically motivated or reflected a dominant personal identity but his portrayal of personal need was certainly not developed as far as it might have been. Tramadol, the item which was missing from his prescription, is a drug which is used to treat moderate to severe, post-surgical or chronic pain (MedlinePlus 2005) and yet he makes no reference to the condition for which it is needed. Although he adopts a lifeworld frame, he avoids "pain talk" (Heath 1989), thus observing what paradoxically appears to be one of the tacit norms of front desk talk (see §6.3.3), the non-mention of medical problems[49].

In this encounter, both participants play out roles of the type identified by Parsons (1952) for doctors and patients: the receptionist is positioned as an expert member of the medical team and the patient as needy and dependent (see §2.1.1). However, as

[49] Non-mention of medical problems helps to maintain patient confidentiality.

the next example shows, neither the strict adherence to an institutional script, the non-issue of an apology nor collaboration in a patient's negative self-evaluation is inevitable in a front-desk encounter and problems can be dealt with quite differently.

7.2 The Brownblake chemist: A missing prescription

In this example the existence of a problem emerges when the receptionist is unable to find the repeat prescription slip which the patient has come to collect. After making some enquiries, she discovers that the prescription is waiting for collection at a nearby chemist's. The encounter begins in the routine manner for a repeat prescription collection, with a Service Orientation sequence.

Extract 7.2

(Practice B, Disc 2, Track 1, 04-47, F/61-75/lw/om)

1	RB2:	hi . can I help (3) hi . can I help?
2	PB56:	em . pick up a prescription for Picken
3	RB2:	okay . I'll take that . and if you could fill that in very quickly for us?
		(11)
4	RB2:	<u>when</u> did you hand the prescription <u>in</u>?
5	PB56:	a week on Wednesday . he says it would be ready
6	R2:	a week on Wednesday
7	PB56:	aha
8	RB2:	nobody else woulda collected it?
9	PB56:	na
10	RB2:	what's the first name?
11	PB56:	Edith (4) 71 stroke 1 Timmins Road
12	RB2:	(1 min 26 seconds) it wouldn'ta gone straight to the ↑chemist? or (.)
13		what chemist do you <u>use</u>?
14	PB56:	the Brownblake
15	RB2:	oh . hold on a s<u>e</u>cond (*calls the Brownblake pharmacy)*

The service signal (line 1) projects a hybrid style which combines informality ('hi') and service ('can I help?'). The concentration level of PB56 appears to be low, since RA2 repeats the signal when PB56 does not at first respond. The service bid of PB56

(line 2) is hesitant ('em'), suggesting uncertainty[50], but elliptical (subject and operator are deleted), suggesting familiarity with front desk routines. During an eleven second interval after consent form and questionnaire have been exchanged (line 3), RB2 leaves the front desk to check the repeat prescription file. She returns without the prescription and immediately applies institutional procedure in the form of an interrogative series (Zimmerman 1992) through which she aims to determine the facts of the case (lines 4-14).

Like RA2 in Extract 7.1, RB2 begins the Information Check with a direct question (line 4) and then alternates between direct WH questions (lines 10 and 13) and declarative questions (lines 8 and 12). The WH questions are of the type routinely asked at the front desk as part of an Information Check but the declarative ones, in which RB2 makes suggestions about what might have happened to the prescription, are non-routine, in the sense that they are proposed problem solutions, and involve a face threat because they hint that the patient could be responsible for the problem. The declarative question types are less coercive and mitigate this face threat (see Woodbury 1984; Luchjenbroers 1997), as do the 'option-creating' 'or' tag after the question in line 12 and the solidarity-building informal stylistic features ('woulda', 'wouldn'ta), which mirror the patient's own informal style. Seemingly aware that there is a problem, the patient legitimises her prescription claim by offering independent corroboration of her entitlement (Edwards and Potter 1992), in the form of a reported statement by the doctor ('he says it would be ready', line 5). The non-standard use of a present simple tense for the reporting verb gives immediacy to the claim, as PB56 animates an institutional voice. She also collaborates with the investigative work of RB2 by answering her questions succinctly (lines 7, 9 and 14) and by supplying her address without prompting (line 11), thus showing awareness of the normal procedure during prescription collection.

RB2 reacts to the naming of the patient's chemist with a newsmarker, 'oh', which is immediately followed by an unexplained instruction to PB56 to wait. Although her utterance is softened by informal usage ('hold on') and the vague time reference ('a

[50] The filled pause may also function as a discourse marker, signalling that there is upcoming material with high information value (Swerts 1998).

second') (see Channell 1994), RB2 is similar to RA2 in her use at this point of an imperative form ('hold on a second', line 15), suggesting that she too views the interruption of the dialogue with the patient for operational reasons as an entitlement rather than a request which requires remedial face work. RB2 again leaves the desk, this time to call the Brownblake chemist, and when she returns a resolution has been found.

16 RB2: your last prescription done here was on the t:wenty-fourth of the fourth?
17 PB56: (1) that was (.) a week past Wednesday?
18 RB2: mhm
19 PB56: aye
20 RB2: that's in the chemist at Brownblake
21 PB56: is it?
22 RB2: aha
23 PB56: I don't know how it got there then cos I al- . I always lift it (.) frae here
24 RB2: right . I'm really no sh- . I mean I phoned the chemist and they
25 certainly said they'd got one . well they just g- . did one on the twenty-
26 eighth so I take it it's that for Coproxamol, Thyroxin and Ferrous Sulphate?
27 PB56: mhm
28 RB2: yeah
29 PB56: (1) so it was . the tablets would be lying up there then?
30 RB2: (.) I wonder if they're still there . right . hold on (.) presume they are
31 . she never said (*calls the pharmacy again*)

Adhering to institutional procedures, RB2 begins with a confirmation request (line 16). PB56, after checking that she has understood this information correctly through an insertion sequence (lines 17-18) in which she reformulates the receptionist's abstract, numerical 't:wenty-fourth of the fourth' with her personal perspective on time, 'a week past Wednesday', provides confirmation (line 19). RB2 then offers a resolution: 'that's in the chemist at Brownblake' (line 20). Using intonation indicative of surprise ('is it?'), PB56 again checks the information (lines 21-22) before indirectly denying responsibility for the unexpected outcome (line 23). In doing this she shows evidence of uncertainty in the restart ('I al-') and the mid-clause pause ('I always lift it (.) frae here'). RA2 is also indecisive (lines 24-26) and breaks

off mid-utterance ('I'm really no sh-') before producing a repair which seems to be in Schiffrin's (2006: 37) "appropriateness" category, answering the question "do I want to say it this way?". RB2 signposts the repair with 'I mean', a solidarity marker (Fraser 1990) which asks for attention when a speaker modifies an earlier idea (Schiffrin 1987). Rather than presenting the information as a personal responsibility, RA2 here offers independent corroboration for her statement ('I phoned the chemist and they certainly said they'd got one'), before breaking off and repairing for a second time ('well they just g- . did one'), this time opening with the dispreference marker 'well'. She finally recovers her fluency when listing the names of the prescription items, perhaps after finding the prescription details on the computer.

During this sequence RB2 and PB56 work hard to establish shared understanding, making five uses each of minimal responses ('mhm', 'aye', 'aha', ''mhm', 'yeah') and the verb 'be' as well as using verbs of saying, thinking and meaning. The indecisiveness of RB2 in the sequence may reflect a realisation that she did not ask for all the relevant information during the earlier telephone conversation, since she goes on to make another call to the chemist (lines 30-31), openly revealing her uncertainty to PB56 both in her choice of verbs ('wonder', 'presume') and the further attribution of authority to her contact at the chemist's ('she never said'). RB2 is, however, decisive when she decides upon a course of action and again instructs the patient to wait with an imperative verb ('hold on'). The possibility that, despite her disclaimer, the patient is at fault over this prescription makes the situation one of continuing face threat. RA2 continues to mitigate this by aligning herself with the patient stylistically by using informal ('mhm' and 'aha') and local Scottish ('I'm really no') items, while RB56 maintains the vernacular style ('a week past Wednesday?', 'aye', 'lift', 'frae') which she has used throughout the encounter.

As the final extract from this encounter shows, although PB56 maintains the same style throughout, she does gradually modify her attitude to the problem.

(*RB2 is speaking to a member of the chemist's staff*)

32 PB56: (*during pause in call*) I need the Thyroxin you see {RB2: mhm} (2) I dinnae
33 understand that . it's a mystery to me

34 RB2: (*continues to speak to pharmacy representative*)
35 PB56: unless I've been . unless I've been harassed
36 RB2: (*completes call*) I don't know how it's got there but the prescription's
37 sitting in Brownblake for you to collect (.) your medication's there . your
38 tablets are there . so I don't know how it got there {PB56: mhm . mhm} I
39 can only apologise
40 PB56: it's alright . I dinnae understand it . unless I've . missed a day somewhere
41 RB2: okay
42 PB56: thanks very much
43 RB2: bye

During the receptionist's two minute conversation with the chemist's assistant, RB56 makes a series of evaluations of her own cognitive and emotional state as needy ('I need the Thyroxin'), confused ('I dinnae understand that . it's a mystery to me'), troubled and non-agentive ('unless I've been harassed') (lines 32-35). These comments may constitute a recognition on her part that the problem has arisen because of her own mistake, since they provide an account in which she claims "reduced responsibility by virtue of reduced competence" (Goffman 1971:111).

Ignoring the negative self-evaluation of RB56, RB2 responds with a repeated admission of her own limitations ('I don't know how it's got there', 'I don't know how it got there'), continuing also with occasional markers of an affiliative local dialect style ('it's got there', 'sitting in Brownblake'). At the same time she provides resolution through a semi-ritualised series of information statements which clearly inform the patient of the whereabouts of her prescription. She also saves face both for the practice and the patient by issuing an unambiguous apology. By using a first person pronoun in her apology ('I can only apologise'), RB2 assumes responsibility for the performance of the practice as a whole while, by using a performative verb, she gives her apology strong illocutionary force, at the same time both intensifying the apology and protecting her own face with the disclaimer 'can only'. PB56 provides relief after the apology ('it's alright'), which seems to give her the necessary face cover for a continuing assumption of responsibility ('I dinnae understand it . unless I've . missed a day somewhere'). After the receptionist signals

a pre-closing with 'okay' (Schegloff and Sacks 1973), the encounter ends with a relatively unusual exchange of strong thanks from the patient, 'thank you very much', which accounts for less than one quarter of patient thanking tokens at Practice B, followed by 'bye' from the receptionist, one of only eight farewells initiated by receptionists at Practice B[51]. As Clark and Wade French (1981) point out, both forms are more likely to occur at the end of encounters when clients are particularly appreciative of the service which they have received or service providers have revealed more than is customary about themselves by making and then correcting mistakes.

The stance of PB54 in this encounter is similar in some respects to that of PA35 in Extract 7.1. Like PA35, she denies personal agency and makes negative self-evaluations, foregrounding a non-agentive, epistemic self, in which beliefs, feelings and wants are more salient than actions and goals (Bruner 1990; Schiffrin 1996). However, the position of RB2 differs substantially from that of RA2. Although she concentrates throughout the encounter on the transactional goal of resolving the patient's problem, in contrast with RA2 she consistently builds solidarity with RB56 by using an informal speech style, which includes local dialect features similar to those in the patient's own talk, and reduces asymmetry by revealing her own limitations, while ignoring those to which RB56 latterly confesses. She also assumes responsibility for the problem, even when there is evidence that the patient may have made a mistake. The drug treatment which PB54 is receiving suggests that she is suffering from hyperthyroidism, a condition whose side-effects include memory loss, fatigue and weakness (Endocrineweb 2005). It may be that RA2 is aware of this and adopts a position through which it is ensured that the patient does not lose face as a result of a problem which has been caused indirectly by her illness. Again though, it is to be noted that the illness itself is not mentioned.

[51] Patients also use goodbyes 4 times and there are 3 reciprocal goodbyes.

7.3 The nine o'clock: A missed appointment

The third problem, which occurred at Practice C, differs from the first two because it concerns an appointment rather than a prescription and because a receptionist is responsible for the underlying error. The patient, PC6, has been given an emergency appointment (see §4.4.1, Extract 4.3) but the receptionist (RC2) has not logged it into the computer, with the result that PC6 has not been called by the doctor. At the point when PC6 approaches the desk at least forty minutes have passed since the expected appointment time and he has been waiting for almost an hour. The opening stages of the encounter are shown in Extract 7.3.

Extract 7.3

(Practice C, Disc 1, 67-25, M/41-60/ly/ey)

1	PC6:	excuse me . I was just wondering if (?you could help me) . em (.) I asked for
2		an appointment for . and they said there was a cancellation at nine o'clock
3		. was it for Murray (.) was it for Murray Browne ‖ was it for doctor
4	RC1:	‖ and your name please
5	PC6:	Robin Pae . was it
6	RC1:	(.) e:m . no . er (1) there was a nine forty this morning for Dr Nash but it's
7		past so
8	PC6:	oh no I g- . I just spoke to your colleague here . I came in . and they said
9		there was a cancellation at nine o'clock

PC6 begins with a service bid in which he outlines the problem (lines 1-3). His use (line 1) both of the anticipatory apology ('excuse me') and the hedged conventionally polite verb ('I was just wondering') suggest that he is aware that, by returning to the desk and questioning the service arrangements, he is threatening the receptionist's face. His two-part narrative account ('em (.) I asked for an appointment for . and they said there was a cancellation at nine o'clock') is preceded by a hesitation marker and a pause and the first clause is left incomplete. It is followed by a fragmented three-part self-repair series during which PC6 tries to provide the name of the doctor ('was it for Murray (.) was it for Murray Browne . was it for doctor'). During this service bid, PC6 protects his own face by attributing

responsibility for the appointment to an institutional collective ('they said', line 2) and by making the repair sequence both interrogative and temporally distant. Although his formal, Standard Scottish English speech style suggests that PC6 has a different social background from PA35 and PB54, with their informal, vernacular dialect styles, his problem presentation has features in common with theirs. Like PA35 he produces a hesitant narrative account and, like PB54, he legitimises his claim by offering independent corroboration.

RC1 responds to the service bid by initiating an Information Check, using her preferred routine 'and your name please?' (see Appendix 3, p.458). Although the routine includes the politeness marker 'please', this response interrupts the patient (lines 3-4) who, after giving his own name, continues the self-repair series in which he seeks to give that of the doctor. It appears that, for this receptionist too, the institutional goal is more salient than interpersonal considerations. However, as RC1 goes on to consult the computer record, she shows unusual signs of hesitancy and uncertainty ('(.) e:m . no . er (1)')[52] before she reaches the firm, although mistaken, conclusion that PC6 was a candidate for a different appointment (lines 6-7). The 'oh no' of PC6 (line 8), which directly contradicts RC1 and indirectly questions the efficiency of the practice, is followed by the self-initiated self-repair of 'I g-' to 'I just spoke'. It seems likely that 'I g-' would have become 'I got an appointment', a statement which would have been unsupported by any appeal to institutional authority. However, in the repair PC6 forcefully restates his case by including another institutional attribution as well as an additional narrative feature ('I just spoke to your colleague here . I came in . and they said there was a cancellation'). The attribution 'I just spoke to your colleague here' is given additional prominence because it is the first discourse unit in this turn, although in real time it must have followed the patient's entry to the practice, which is specifically mentioned in the next clause ('I came in'). By constructing the narrative in this way PC6 foregrounds the most important piece of information and, at the same time, validates his claim to institutional knowledge (Drew 1991; Silverman 1987), both by showing that he had

[52] Half of the eight filled pauses in the discourse of RC1 occur in this encounter. Three of the remaining four seem to function as face-protecting hedges for RC1, who is 28, during encounters with patients in the youngest age group.

been present at the front desk earlier and by linking his 'I' in a chain of person reference with the practice representatives 'your colleague' and the generic institutional 'they'.

In response to the unsuccessful outcome of this phase of the encounter, RC1 resumes the floor with a confirmation stage (lines 10-11), which is followed by another resolution proposal (line 12).

10	RC1:	for today?
11	PC6:	yeah
12	RC1:	right . well it's been filled and it's
13	PC6:	(.) ‖ R-
14	RC1:	‖ was it for you?
15	PC6:	yes . Robin Pae . P A E
16	RC1:	(2) right . lovely . if you'll just have a seat I'll let him . mm?

In this sequence, receptionist and patient initially remain at odds. Although RC1 establishes through the confirmation check (lines 10-11) that PC6 has sought a same-day appointment, her resolution proposal is negative (line 12) and formulated as a rebuttal. The first discourse marker in this turn, 'right', is a transitional item, which indicates anticipated imminent closure of this sequence (Schiffrin 1987; McCarthy 2003), while the second, 'well', signals to the patient that he will not obtain his goal. Similarly to RA2 in her response to PA35 (Extract 7.1, line 5), RC1 does not mitigate the face threat to RC6 which the appointment refusal entails. Nor, when she subsequently realises that the appointment is indeed for PC6 (line 14), does she offer any remedy. Instead she signals another transactional boundary ('right') before producing her preferred evaluative item, the high-grade assessment 'lovely', which, Antaki (2002: 5) suggests, "makes a special display of resuming a closing which has been suspended". This is followed by a mitigated version of the instruction sequence, 'if you'll just have a seat I'll let him' (line 16), which she routinely uses for the resolution of check-in encounters.

It seems here that the dominant institutional routine overrides any awareness of fault or thought of providing remedy. It also seems that RC1 has not yet fully understood the problem since she uses the object pronoun 'him' to refer to the doctor (line 16) when, in fact, PC6 has been given an appointment with a female doctor. One can infer that this acts as a signal to PC6, who intervenes before RC1 completes her statement, causing her to break off and offer him the floor through the interrogative continuer 'mm?'. PC6 then opens a new sequence in which the service bid is again reformulated and an alternative interim resolution is offered.

17 PC6: w- . I mean . I spoke to your colleague here who said 'just take a seat .
18 there's one at nine o'clock'
19 RC1: yes (2) em (1) she should be finished . if you'll give me a minute I'll
20 speak to her
21 PC6: I just . I mean it was
22 RC1: if you'll have a seat I'll speak to them for you
(*PC6 goes into waiting room*)

This time, PC6 positions himself slightly differently in the bid. At the beginning of his turn we see him self-repairing yet again as he seeks an appropriate formulation ('w- . I mean'). The broken-off 'w-', which, it seems likely, would have been completed as either 'well' or a WH question, is replaced by 'I spoke to your colleague', in a change of direction which is marked by the solidarity seeking 'I mean' (see §7.2). The conversation with the reception colleague of RC1 is this time reported as direct speech which, Labov (1997: 409) argues, "provides a way to intensify certain narrative events, thereby warding off indifferent stances to the reported talk" and, Briggs (1996: 27) claims, "turns narrators into ventriloquists […] rendering their own positions both powerful and invisible". Because the earlier encounter has also been transcribed, we also know that this 'active voicing' (Wooffitt 1992) is a fiction, which is perhaps unconsciously modelled on the instruction given a moment earlier by RC1 (line 16).

Kraft (2005) suggests that when clients complain in service encounters, they begin with a *neutral* statement of the problem and *rational* argument, but, if unsuccessful,

make *emotional* expression of anger and discontent or use a *confrontational* style, with accusation, insult and rejection of responsibility. While PC6 does not at this point become confrontational his narrative certainly becomes more emotional. The discourse marker 'I mean' highlights the personal nature of the experience and the direct reporting makes his predicament more real. The increased emotion of PC6 is even more salient in his next turn (line 21), which has no information content but consists of two clause openings, both of which begin with 'I' ('I just . I mean it was') and so maintain the personal perspective. The repetition of the discourse marker 'I mean' makes a continuing appeal to RC1 to attend to his claim while the adverb 'just', seems to function as an imposition diminisher (Aijmer 2002).

In her first response (lines 19-20), RC1 attends to the renewed bid, again at first hesitantly ('yes (2) em (1)'), by stating her intention to speak to a 'her' who seems to be RC2, the receptionist who dealt with PC6 during the earlier encounter. The 'if' clause, 'if you'll give me a minute', in which she asks for the opportunity to do this is ambiguous: on the one hand it can be understood as an indirect polite request to PC6 to continue his wait and, on the other, as implying that he is putting her under pressure. In her second response (line 22), after it becomes apparent that PC6 is not yet satisfied, RC1 produces a similar construction, 'if you'll have a seat I'll speak to them for you', but this time it has the function of offering as well as requesting. The approach here is less face-threatening than in RC1's previous 'if' clause and the choice of the pronoun 'them', in place of the earlier 'her', implies that RC1 will also broaden the scope of her enquiry and speak to both receptionist and doctor. The distance between PC6 and RC1 is emphasised by the temporal distance of the verb systems each uses. Where PC6 consistently uses past simple verbs, four of the five verbs used by RC2 have future reference with the result that the two participants do not meet in the interactional present.

Throughout this encounter, PC6 has been obliged to overcome the tendency of RC1 to depend on the computer record. Although faltering in manner, he has been active in presenting his case, as RC1 has repeatedly drawn on institutional routines which have broken down. When he goes to sit in the waiting room as requested, it seems

that PC6 has achieved the interim goal of persuading RC1 to accept the validity of his appointment claim but, after two and a half minutes, he returns to the desk to ask for more information.

22	PC6:	do you know what's happening?
23	RC1:	em . yes . I've spoken to her . she's about to see you next .
24		‖ if you just
25	PC6:	‖ yes . was I- . was I <u>in</u> for the nine o'clock?
26	RC1:	yes . you were in for a nine o'clock slot
27	PC6:	oh
28	RC1:	I- . it just might've gotten overlooked . I'm sorry
29	PC6:	I- . I- I- ‖ I got that impression . yeah
30	RC1:	‖ but she's going to see you . she <u>is</u> going to see you
31	PC6:	aha . okay . thanks

In contrast with the remedial opening move made when he first returned to the desk, this time PC6 asks an unmitigated direct question (line 22). RC1 responds with a five component turn (line 23-24) consisting of a turn-initial hesitator, which suggests that she is not prepared for the directness of the question, an affirmative answer, a knowledge attribution, which both removes personal agency and substantiates her next utterance, a confirmation that the doctor will shortly see PC6. Rather than naming the doctor, RC1 refers to her using the pronouns 'her' and 'she'. In doing this she indirectly accepts the point of view which PC6 had presented earlier, since it was he who introduced the name of Dr Murray Browne into the discourse (line 3). In the fifth component of the turn RC1 slips once again into the 'if you just' routine and is apparently about to ask PC6 to return to the waiting room. However, PC6 again interrupts her to take the floor (line 25).

PC6 claims the floor with a turn-initial 'yes' (see Jucker and Smith 1998). This is followed by a self-repair which leads into a request for clarification of the status of the earlier appointment offer ('was I- . was I <u>in</u> for the nine o'clock?'). The content of this turn suggests that PC6 is not satisfied with the level of information he has been given and is seeking acknowledgement of the error as well as remedy for his

consequent loss of face. The second part of this adjacency pair (line 26) echoes the first part, although, in a small display of her superior knowledge, when answering, RC1 reformulates the definite reference of PC6 to '*the* nine o'clock' to the indefinite '*a* nine o'clock slot', downgrading the importance of the PC6 appointment by positioning it as one of many. By giving feedback with the interjection 'oh', PC6 orients to the information as a change in his state of knowledge (Heritage 1984b) rather than an answer to his question. Furthermore, like a response cry, the 'reactive particle' (Goodwin 1996a) calls for a further reaction from the other participant.

RC1, a speaker of American English, provides this reaction (line 28) in the form of a hedged acknowledgement of responsibility ('it just might've gotten overlooked'), in which a passive construction is used and no agency is admitted, which is followed by a conventional expression of regret, 'I'm sorry'. PC6 orients to the account rather than the apology and claims the floor with three repetitions of 'I'. These are followed by the vague and understated agreement 'I got that impression . yeah', which, by flouting the maxims of quality and quantity, generates a negative implicature. RC1 appears to anticipate that PC6 will require more remedial action since she takes the floor at the first opportunity and gives him repeated reassurance that he will be seen ('but she's going to see you . she <u>is</u> going to see you'). It initially appears that both the transactional and interpersonal goals of PC6 have now been met, since he reacts to the additional remedy with a positive acknowledgement token, apparently changing frame because, for the first time in this encounter, he uses an informal lexical item ('aha'). He also provides relief to the receptionist for her expanded remedial work ('okay') and consolidates his appreciation with a thanking move ('thanks'). However, after a six second silence, the encounter continues.

31	PC6:	aha . okay . thanks (6) er . er . did . excuse me
32	RC1:	yes?
33	PC6:	did it . do you know when she's goin- . how much longer it's going to be?
34	RC1:	she's on her last patient . she's had him for a while .
35		‖ it should be quite quickly
36	PC6:	‖ yeah . so I was just . your colleague

Again hesitantly ('er . er . did') and with mitigation ('excuse me'), and again after self-repair, PC6 asks how much longer he should expect to wait ('did it . do you know when she's goin- . how much longer it's going to be?'). RC1 facilitates the question with a non-explicit elicitor ('yes?') and provides an answer ('she's on her last patient . she's had him for a while . it should be quite quickly'). Both the elicitor and the answer have a transactional focus and the three part statement, without being definite ('it should be quite quickly'), gives PC6 a fairly strong assurance that he will soon see the doctor. When describing the consultation in which Dr Murray Browne is engaged, RC1 seems to be using the voice of an institutional insider, both in the non-explicit person referent 'she', the preposition 'on' and the verb 'have' ('she's had him for a while'), and may even be using the doctor's own words without attribution.

Before RC1 has finished speaking (lines 35-36), PC6 prepares to ask another question ('yeah . so I was just . your colleague'). The positive acknowledgement token is again used as a floor-claiming device and the discourse marker 'so' marks the forthcoming action as already on the speaker's agenda (Bolden 2005). It appears that the topic will concern the patient's earlier encounter with RC2. However, PC6, although still standing at the front desk, is obliged to break off his turn before it is complete, because RC1 ends the encounter by moving away from PC6 and turning her gaze elsewhere (Goodwin 1981). PC6 hesitates for a moment and then leaves the desk himself. It seems that, having provided PC6 with all the available information about his appointment, RC1 treats the matter as closed. By ignoring his next move and remaining silent, she disregards the norms of conversational cooperation (Grice 1975), committing a strongly dispreferred action (see §5.1.3) which in many circumstances would be interpreted as face aggravation. After the moment of hesitation, PC6 seems to decide against pursuing the matter any further, thus tacitly accepting the receptionist's power.

Sarangi and Slembrouk (1996: 182) comment that asymmetry in institutional encounters "is constituted in the ways in which information is (not) exchanged or can (not) be exchanged, or in the way that information is transformed in the processes that make up institutional contacts". Initially RC1 constructs asymmetry by giving

more weight to the institutionally constituted information which she can see on the computer screen than to the patient's version of events and, even after the validity of the patient's story has been confirmed, perfunctorily closes the encounter in a strong display of institutional power. However, PC6 resists this asymmetry. Although, like the patients in the previous examples, he is hesitant in manner and the construction of his contributions is tentative and fragmented, PC6 holds his place in the discourse, initiating moves not only in the initial summons to the receptionist but also by orienting in his responses to his own agenda. Furthermore, by making repeated demands for access to institutional knowledge, he challenges the way this knowledge has been constituted, building up a case which will override the existing record and so reopen the gateway to the service which he requires. In the persistence with which he exercises his personal agency during this case-building, he has more in common with the consumers described in the Kraft (ibid.) study than with the non-agentive patients who seem to occupy a Parsonian sick role in their dealings with medical receptionists as well as with physicians.

7.4 Conclusions

Systematic comparison of the three encounters which were selected for detailed analysis is not possible because both participants and problem-types differ. However, some common points were found. All three receptionists focused on the problem rather than on the personal reaction of the patient and concentrated on achieving practical outcomes. All three adhered to routine procedures as they attempted to understand and deal with problems. In the case of the missing prescription item (§7.1) this was accomplished quickly since the problem resulted from a transcription error, which could be remedied with relative ease. In the other two cases, resolution of the problem forced receptionists to review the existing record, which led to a disruption of normal procedures. Patients at all three practices included narrative elements in their problem presentation while two of them foregrounded epistemic rather than agentive selves. All three were tentative and hesitant in staking their claims and, although presenting their cases in terms of their personal experiences,

none made reference to the medical conditions which had brought them to the practice.

There were also some contrasts. Receptionist A2 attributed responsibility for the problem to the doctor and showed implicit acceptance of the situational asymmetry by accepting the inexpert self projected by PA35 and adopting a dominant (but helpful) stance towards him. Receptionist B2, taking on the footing of the animator of the practice voice, not only saved the patient's face by accepting responsibility for the problem but also offered a strong apology and, in addition, found interactional means of reducing the impact of the knowledge asymmetry inherent in receptionist and patient roles. Receptionist C1 also eventually acknowledged responsibility for the problem and provided redress, but the force of her acknowledgement was reduced and her apology weak. She also appeared resistant to the patient's claims and inclined to place more faith in the official record than in his version of events. Although the approaches of the three patients were in many ways similar, those at Practices A and B constructed non-agentive versions of self whereas the patient at Practice C showed more personal agency, particularly in his ability to claim the floor and control topic development.

These three encounters also show that patients and receptionists have different scripts for problematic events. Echoing the discursive behaviour of patients during consultations (see e.g. Mishler 1984; Ainsworth-Vaughn 1998; Cordella 2004), patients at the front desk construct narrative versions of the troubled self (see Kupferberg and Green 2005) and occupy lifeworld-based as well as role-specific identities when they describe problems. In contrast, as well as relying on the institutional record held, in all three problem cases described in this chapter, in practice computers, receptionists tend to focus on names, times, and dates. It is possible that the confidence of patients is increased by displays of receptionist mastery both of administrative detail and specialist medical knowledge (see Ogden at al. 2003). However, it may also be that patients are resistant to what Jefferson and Lee (1992: 537) describe as the "general sense of the 'essential indifference' of the service agency to the troubles teller and his or her experiences".

Because my research design did not include either post-encounter interviews with patients or retrospective reviews of the interaction, it is impossible to say how participants actually judged their experiences, but it does seem possible that the strongly contrasting approaches, particularly of the receptionist-patient dyads at Practices A and C, could lead to negative judgements, perhaps on both sides. By remaining within a transactional frame, which excludes interpersonal attention and focuses on ensuring that procedures are being followed correctly, a receptionist is fulfilling her task remit as she aims to resolve the problem efficiently but, in so doing, she ignores the face needs of patients. By concentrating on personal experiences, patients may give unfocused accounts which blur the information content and frustrate receptionists whose main goal is efficiency. Indeed, when I was present in practices for data collection, more than one receptionist commented that patients exaggerated their problems and overplayed their own inadequacies in order to obtain the services which they required.

Although all three patients successfully attained their strategic goals, in my view, the approach taken by the receptionist at Practice B provides the best model for receptionist conduct. By taking responsibility for both the transactional and the interpersonal elements of problem solution, RB2 took both the safest, in the sense that the patient was left with little to complain of, and the most appropriate approach, in that it involved both transactional efficiency and relational sensitivity. In contrast, the receptionist at Practice A was over-assertive and reinforced the patient's negative evaluation of self, while the receptionist at Practice C was under-attentive to the patient's voice and, as a result, may have reduced her own efficiency as well as falling short in relational style.

In my concluding chapter, as well conducting a critical review and summarising the main findings of the study, I will discuss appropriate training models, putting forward proposals for the development of training schemes which are designed to improve understanding between receptionists and patients.

Chapter 8

Review of the research and implications for receptionist training

8.0 Introduction

In the course of this analysis several types of discourse pattern have been identified: those through which front desk tasks are accomplished, those through which relationships are built and maintained by receptionists and patients and those through which both groups construct shifting discourse positions. All these patterns encode social meanings and reflect participant understandings of the social actions in which they are engaged. In this concluding chapter I discuss the social meanings which emerge as the three groups of receptionists and patients who took part in this study co-construct their talk, and then go on to make proposals for the use of the findings in training programmes and suggest future directions for research on front desk talk. First though, I will review the research on which the findings of this study are based, suggesting alternatives to the research design and drawing attention to factors which might have affected the results.

8.1 Review of research

It was found that five aspects of the study might have influenced its outcome: the attitudes of subjects, the method of data collection, problems during data collection, problems with the research design, and the performance of the author. Each of these areas will be discussed in turn.

8.1.1 Attitudes of subjects

As shown in §3.3, all receptionists consented to take part in the research and, in addition, collected consent forms from patients and handed out questionnaires to them. However, it became apparent during visits to practices that attitudes to the research varied. These were made known in three ways: indirectly, from backstage

comments and from the discourse through which consent forms and questionnaires were dealt with, and directly, from comments made to the researcher.

The following backstage comment to a GP at Practice B from the reception manager, who, unusually, was working at the front desk, demonstrates that receptionists experienced the research as an extra burden.

Extract 8.1

Dr: could someone get the last two (?notes) (*patient files*) out for me for open surgery?
RB3: yes sure
Dr: thanks
RB3: I'll get them now
Dr: are you manning the front desk today?
RB3: well . we've got so much going on with this reco:rding thing

A sense of pressure is displayed in this example. However, despite the additional workload occasioned by the research, receptionists would sometimes provide extra guidance about how questionnaires should be completed and even, in the case of RB3, read out questions to patients and fill in the answers for them, (something which they were able to do because the questionnaires asked for information which was already available to receptionists through their work). Thus, although, as Extract 8.1 shows, at times receptionists felt under pressure, they always remained co-operative.

When carrying out the reciprocal action of exchanging consent forms and questionnaires, receptionists also revealed their attitudes to the research through the formulaic speech patterns which they quickly developed to deal with the task (see Appendix 3, p.458). Some, such as RA1 (Extract 8.2) and RA3 (Extract 8.3) treated the research forms as a routine matter, the former using conventional levels of formulaic politeness ('can I', 'please') and the latter minimising the imposition ('just', 'wee'), when dealing with the forms.

Extract 8.2

RA1: and can I give you that form to fill in please

Extract 8.3

RA3: it's just a wee tick-off questionnaire for you to fill in

In contrast, others, such as RA4 (Extract 8.4), distanced themselves from the activity by denying agency (see also §6.1.2).

Extract 8.4

RA4: I've now got to give you one o' these apparently

While the discourse approach of RA4 suggests that she was discomfited by the research, she nevertheless took part without overt resistance, despite her admission during her informal interview that she did not wish to hear her own voice on the recordings because she was highly critical of her own performance. This was not the case with several receptionists at Practice C. While both I and my colleagues had a friendly reception from both administrative and medical staff at Practices A and B, there was resistance to our presence at Practice C which, in one case, approached active resentment. In addition, neither administrative nor medical staff appeared aware of the reason for our presence. Similarly, while almost all receptionists at Practices A and B expressed interest in the research and took part enthusiastically in the feedback sessions which were offered, several at Practice C refused ethnographic interviews, one stated that she did not believe the research was of any value, and very few attended the feedback session.

While it is possible that receptionists were alienated or antagonised by my own approach and that of my assistant, it seems more likely that they experienced the research as an additional and unnecessary responsibility which was imposed on them by their managers. It will be recalled that, while receptionists at Practices A and B consented to take part after reading an information letter, the decision to participate was made at Practice C by the practice manager, who did not share this background information with receptionists (see §3.3.2). As a result, they had not seen the

information sheet, which included an assurance that the data would not be used for professional monitoring or assessment, and may therefore have believed that they were being evaluated. The practice manager's supervision of the data collection did nothing to dispel this impression. Perhaps more seriously, as regards both the ethical acceptability and the validity of the research, there may also have been an effect on the performance of one receptionist at Practice C, who appeared jittery, unsure of procedures and careless in the conduct of her work. This apparent anxiety may have been justified, since the Practice C manager also took control of the transcripts which I later provided and asked a number of questions which so obviously sought evaluations of receptionist performance that I was not willing to answer them.

Overall, circumstantial evidence suggests that most receptionists at Practices A and B wanted the study to be a success and that, even though they saw it as an additional workload, they considered that it would be useful for them professionally. Receptionists at Practice C, on the other hand, were less willing participants and did not see much value in the research. The positive attitudes of receptionists at Practices A and B may have encouraged them to be on their best professional behaviour whereas the resistance of receptionists at Practice C may have had the opposite effect. All did nevertheless cooperate fully in the administration of research forms, and ensured that the procedure ran smoothly and effectively.

Patients also signed up for the study in fairly high numbers and, in the main, seem to have experienced it as a minor imposition. Some requested advice about the completion of questionnaires and others found that they were too rushed to complete them but most patients said very little about the research forms and, as one would expect from participants who had opted in to a study, there were hardly any complaints from the patients who did express their views. Only two patients, both at Practice B, voiced scepticism about the value of the research, one, who was subsequently typified by RB3 as "an awkward customer" in a comment to another patient and the other, as shown in Extract 8.5, in a comment to a receptionist.

Extract 8.5

(Practice B, Disc 1, 23-00, M/61-75/om/)

PB14: I dinnae see any sense in . getting it done . it's quite simple . I just came in and gie you things

As mentioned in Chapter 6, the research was also used by patients to initiate small talk, some of which revealed a belief that the study was being used to evaluate receptionists and a willingness to be cooperative for this reason. However, there is no evidence that the attitudes of patients to the research affected their performance.

8.1.2 Method of data collection

The most marked effect of the method of data collection was the influence that the exchange of consent forms and questionnaires may have had on the discourse. First, as shown in Chapter 4, rather than opening in the normal way, many encounters began with discussion of the research forms while, in others, the discussion of research matters was postponed until the front desk business had been done and dealt with at the end of encounters. This distorted the normal patterns for both openings and closings.

Second, as shown in §6.3.4 and §8.1.1, the research forms occasioned most of the small talk and many of the off-task comments in the data. As a result, no reliable claims can be made about normal levels of small talk. As Schneider (1988) shows, small talk is structured around topics arising from the immediate discourse environment. It may therefore be either that there was more small talk than normal because of the research, or that, because it was such a salient topic, it displaced other matters which would have been the topic of small talk in normal circumstances.

Third, participants were fully aware that recordings were being made and that transcriptions of their talk might be made available to a wider audience. As mentioned in §3.1.4, the 'observer's paradox' is hard to avoid when subjects are aware that they are being recorded and, as Tedlock (1983) has shown, can affect the recipient design of the talk even in the most remote of settings. Duranti (1997a)

however suggests that this effect is usually temporary and the presence of recording equipment ignored, particularly in contexts such as the health care one where it is frequently present (see Strong 1979). In addition, as Drew (1989: 99-100) points out, "the possible disturbance effect" of recording equipment, is only significant if it has an impact on the feature to be analysed.

It is difficult to judge how much the performance of participants was affected by their awareness that their interaction was being recorded. Backstage there was mention by more than one receptionist of the embarrassment of hearing one's own voice on tape but no reference was made to the microphone by patients or receptionists at the desk. However, as mentioned in §6.2.1, when comparisons were made of different encounters in which receptionists were involved, evidence was found that they used a careful, courteous style at the beginning of the period when they were being recorded but relaxed as they became involved in their work (see Labov 1972a). Awareness of recording may therefore have had an impact on some of the features which were being analysed, for example, on speech styles and on levels and styles of remedy. Because patients only took part in one or, at most, two encounters, this type of analysis of their talk was not possible, but the high incidence among patients of colloquial, informal styles suggests that they were not seriously inhibited.

8.1.3 Problems during data collection

Several problems arose during data collection. The most serious of these was the failure to obtain recordings of telephone calls by patients to either Practices A or B, which led to the abandonment of the plan to analyse interaction through this channel. As a result there was only limited evidence for the performance of a gatekeeping role by receptionists, since most appointments were made by telephone. Only 42 appointments were made at the front desk and many (37.5%) of those were prioritised because they were made after consultations at the request of doctors, giving a very partial picture of discourse patterns for appointment-making. This was a great disappointment because it eliminated the possibility of giving full

consideration to how discourse elements contributed to the negotiation of access by patients.

A second problem was observance of the conditions stipulated by the research ethics committee. In order to ensure that non-consenting patients were excluded from recordings I had to be in a position to observe patients approaching the reception desk. As a result, when receptionists were absent, patients sometimes addressed me directly. When questions were asked about medical matters I was able to apologise and explain that I was unable to help but I was sometimes drawn into general discussion with patients which, strictly speaking, the ethics committee wanted me to avoid. There were also a number of occasions when I was unable to avoid overhearing personal information about patients who had not consented to be recorded. The decision was made to remain close to the desk in order to ensure that recorded data were ethically sound but this did result in some inappropriate involvement on my part.

The third problem concerned the research assistants who accompanied me to practices, explained the research to patients and obtained their consent. In the main they were treated courteously, even by those patients who did not consent. There were, however, a number of patients at Practice B who were verbally abusive towards them and a jacket belonging to one research assistant was stolen when she left it unattended for a couple of minutes at this practice. As well as illustrating the type of problem faced by staff at Practice B, these two episodes are reminders that not everyone viewed the research assistants favourably. Although both made major contributions to the research by persuading relatively high numbers of patients to consent, it is also possible that their individual personalities and styles attracted particular types of patient and caused some bias in the results.

8.1.4 Problems resulting from the research design

There were two features of the research design which may have affected the quality of the findings. The first was the decision to make audio rather than video

recordings. Although there were sound reasons for this decision (see §3.1.1), the absence of a visual record limited analytical possibilities both in relation to the participation framework and the relational behaviour of participants. For example, because I was unable to observe moves which were made non-verbally, I made some assumptions about the use of eye contact by receptionists to signal openings and had no evidence of the non-verbal moves which might have contributed to the performance of closings.

A second shortcoming of the research design was the limited value of the ethnographic information. Although the short questionnaires yielded useful information about age and gender, patients found it difficult to remember when or how often they attended practices, with the result that their answers to these questions were not reliable. I also concluded that, for close analysis of encounters, such as those in Chapter 7, it would have been useful to have far more information about patients. For example, if participants had been invited to comment on the interaction or to provide respondent validation of my own interpretations, it would have reduced the potential for error as well as providing insights from alternative perspectives (see Bloor 1997). If an ethically and practically sound manner of obtaining this information could be found, it would be a useful addition to future studies.

Whereas the pursuit of respondent validation would have complicated the research design, the interviews with receptionists could have been simplified and targeted more carefully on topics relevant to the analysis. Dingwall (1997) points out that informality will not bring the observer closer to the truth, and that sociological interviews are always forms of account (see Scott and Lyman 1981), which are more likely to represent views of the natural order of the social setting rather than its day-to-day reality. It might therefore have been better to pose more clearly defined questions to receptionists, as well as inviting them to comment retrospectively on recordings and transcriptions. Similarly, the research diary which was kept during visits to practices could have been targeted more carefully on relevant information, such as the paralinguistic features of closings.

8.1.5 Performance of researcher

The results were naturally also influenced by my own attitudes and prejudices. Miller and Dingwall (1997) point out that there are two contexts for all research: the research setting and the anticipated audience. Part of the work of the researcher is thus to combine 'being there', on site, with 'being here', translating experience into words for academic audience and creating an appropriate frame (Goffman 1974; Hunt and Benford 1997).

'Being there' was not at first easy. Unsurprisingly, experienced medical professionals had to be persuaded of the value of a study to be carried out by a novice researcher from another disciplinary culture. A series of institutional representatives had to be convinced that the research proposal was feasible, financially viable and of potential benefit to practices, a process which took many months. The experience of negotiating approval, strengthened my initial view, which was based as much on popular opinion as sound research, that access to the health service was not easy. However, after meeting, sharing conversations and establishing relationships with receptionists, I came to feel sympathy for them, particularly when they spoke of the sheer volume of patient demand and the frequently negative or dismissive attitudes towards them. Rather than regarding them as obstructive gatekeepers, I came to view them as a group of well-intentioned women who were doing a good job in difficult circumstances. Both the early problems and the later sympathies may have influenced my approach.

The positive view I had of receptionists at Practices A and B was further augmented by their responses to my work. As described in §8.3, Practice B became so involved in the research that I was asked by the practice and reception managers to undertake a follow-up study in order to assess whether the feedback session there had made an impact on receptionists' discourse styles. In contrast, the negative reception which I received at Practice C was reinforced by the poor response to the feedback session which I gave there. I also came to feel particular sympathy for the receptionists at

Practice B, because of the extremely professional approach they took while dealing with a very troubled group of patients, which included recovering drug addicts, the unemployed, the chronically sick, refugees, asylum seekers and single teenage parents. I was also fearful that the Practice C manager would use my work to assess receptionist performance which, as discussed in §3.1.2, was far from my intention. This too may have prejudiced my analysis.

In relation to 'being here' Miller (1997: 7) states that "audience considerations are implicated in qualitative researchers' methodological choices, even if the researchers are unaware of the implications, and if they are not explicitly acknowledged in research reports". This was an issue for this study since it had several potential audiences: those from the academic linguistic and primary care research communities and those who were more concerned with receptionist training and practice. As a result, different styles of analysis and terminology were used when presentations on the study were given in the various settings, something which may have had some impact on the way that the findings are presented here.

8.1.6 Summary

With the exception of the failure to collect data from telephone calls and the inadequate provision of information to receptionists at Practice C before data collection began, the research method was successfully implemented. However both the data which were collected and the content of the analysis may have been affected by methodological and personal factors. These must be taken into consideration in any assessment of the overall validity and reliability of the research findings.

8.2 Social meaning in front desk discourse

The following questions were posed at the outset of the study.

1. What are the typical patterns of staging and sequencing in the speech routines used by receptionists and patients in their interaction?

2. What variations are there in the enactment of these patterns?
3. What do such variations reveal about the participants' construction and understanding of the interaction?
4. How can the findings be used to improve receptionist communication through training?

Answers to the first three questions will be discussed in this section and there will be discussion of the fourth in §8.3.

The discourse patterns in front desk encounters were found to share generic features with those of other service encounters of short duration, more so in their transactional structure than in their relational and interpersonal norms. The staging and sequencing of the task content of the talk was very similar in encounters at all three sites whereas relational styles varied by practice, by participant and by activity type. Whatever the dominant relational style, it was realised in most encounters through formulaic routines. A wider range of discourse forms was drawn on only when non-standard events occurred or problems were resolved. Variations in the discourse also revealed a range of subtly differentiated constructions and understandings of the interaction, as expressed, for example, through differing amounts of remedial action, levels of formality and attitudes to personal agency. However, a broad trend could be discerned towards maintaining a common institutional reality, which manifested itself in a number of ways.

Both receptionists and patients appeared to orient strongly towards task completion, remaining within the complementary roles of service provider and service seeker implicit in Merritt's (1976) definition of a service encounter (see §1.1), and, in contrast with participants in service encounters in many other settings, treating relational matters as a secondary concern. The absence of small talk may have reflected the pressure on receptionists to complete their work for, like the receptionists in Cicourel's (2004) study, they were often hard-pressed to keep up with patient requirements and made alternate use of numerous cultural tools (face-to-face, voice-to-voice, telephone, answer-phone, computer, memos, diaries, case notes,

prescriptions) (Wertsch 1998), as they switched between interlocutors (patients, receptionists, administrative personnel, clinical staff, drug company representatives, hospital and hospice staff, police officers, couriers). However, this does not account for the low levels of remedial action from receptionists, particularly the tendency to omit apologies when service needs were not met, or the tendency of patients to provide remedy when they omitted institutionally relevant information. These tendencies are contrary to what one might expect for a situation in which the provider is required to deliver goods or services to the seeker.

One factor which may account for these patterns of remedy is the institutional structure of the NHS. Although GPs are independent contractors, their funding comes through the state rather than directly from patients and the relationship between payment and receipt of services is thus obscured. Furthermore, particularly in rural areas, GP practices have a monopoly (see §2.1.1) and there is consequently no incentive or need to market the service or compete for patients, for example, by sustaining high levels of courtesy or customer-centred rapport. Brown and Levinson (1978/1987) claim that the level of remedial action required in any situation is determined by the relationship between the power of participants, the social distance between them and the degree of imposition represented by the situation. Here the dimensions of power and imposition appeared to count for more than that of distance since patients accounted and apologised for perceived impositions while receptionists did not mitigate the power which ensued from their role.

The power asymmetry between receptionists and patients is inherent in the front desk situation. First, like the doctors described by Hak (2004), receptionists are ‘at home’ while patients are visitors. This gives them greater competence in the completion of tasks, which they perform far more often than patients, who may attend their GP practice only rarely, as well as expert insider knowledge of both procedures and patient information. Second, because they work for an organisation which, as Jean (2004: 389) points out, “engenders work conditions that are favourable to rationing”, receptionists are obliged to make gatekeeping decisions which, although they may not involve rationing, certainly involve prioritisation and therefore also triage. Lukes

(2005: 28) has pointed out that people "accept their role in the existing order of things because they can see or imagine no alternative to it, or because they see it as natural and unchangeable". This seems to be the case for the receptionists in this study. I heard no comments which indicated that receptionists regard themselves as powerful in relation to patients. Indeed, they appeared to be more aware of their lowly position in the NHS as a whole and, in some cases, also oppressed by the difficulty of matching patients' demand for appointments with the supplies which were available (see §2.1.2).

Patients, for their part, collaborated in treating receptionist decision-making as a situational norm. Although patients rarely make mention of the worrying health problems which bring them to practices, there are patients at all three practices who show signs, in their self-presentation as needy, inexpert or non-agentive, of having the physical needs, emotional anxieties and situational dependency which Parsons associates with the sick role (see §2.1.1). A 'naturalised' discourse system (Fairclough 1992; Foucault 1980) thus exists in which both groups of participants collaborate in dealing only with surface details. Receptionists, on the whole, do not contribute directly to the work of care, neither do patients expect them to do so. In parallel with this, receptionists do not seem to regard themselves as collectively accountable for practice decisions but attribute agency elsewhere. It is only the receptionists who have taken 'ownership' of their professions and regard themselves as important members of a team which is dedicated to providing a high quality service, who maintain the levels of responsibility and "affective neutrality" associated with the professional medical goal of similar treatment for all. Others, as well as denying personal responsibility, appear to differentiate between patients, protecting the face of some more than others and favouring them when gatekeeping decisions are made.

Although there are variations in the degree to which participants are subsumed by their roles and in the levels of formality and affective neutrality with which the front desk work is accomplished, both receptionists and patients appear to be constrained by discourse norms which discourage them from drawing on all the symbolic

linguistic capital available to them and confine them within narrower situational identities and roles. This leads to a situation in which participants are trapped by their own conversational routines which, as Coulmas (1981: 4) suggests, "are tacit agreements, which the members of a community presume to be shared by every reasonable co-member". By modifying and developing these routines, participants might also change and develop their practice. This is the role of training.

8.3 Receptionist training

The fourth research question, "How can the findings be used to improve receptionist communication through training?", could not be answered until the data analysis had been completed and I had drawn some conclusions about the verbal practices of the receptionists who were observed. The aspects of discourse practice which I eventually came to consider important to highlight during receptionist training are those described in §8.2: the orientation towards efficiency and the accompanying tendency towards impersonality; the low levels of remedial action; the unmitigated exercise of institutional power and the overall formality of the genre. It also seems vital that awareness be raised of the relativity of cultural practices and preferences, for example in choices of name (Bargiela et al. 2002; Zegarac and Pennington 2000), and attention drawn to lapses in professionalism, for example when a receptionist fails to maintain the confidentiality of patients, does not listen to them, does not confirm patient information or shows little regard for patients' face needs.

These priorities are the first of three strands which feed into my recommendations for the use of authentic data in receptionist training. The second and third are the findings from previous research and practice in this area (see §2.4) and their implementation in my own feedback sessions for receptionists. In the next section, therefore, I discuss, in order of use, the materials which were trialled at the three practices, with frequent reference to the findings from other studies.

8.3.1 Feedback sessions

Feedback sessions at all three practices were held during receptionists' monthly training afternoons. The time available at each practice was just over one hour and, in each case, after discussing transcription procedures, providing an overview of the talk which was recorded at the practice, giving a copy of the transcribed data to individual receptionists and, at practice A, also a personal work profile (see e.g. Appendix 5, p.463), I asked those present to complete a series of tasks, either individually or in pairs. The first session was held at Practice A, before data had been collected at either of the other two practices. Following the example of others (e.g. Candlin 2000; Carter and McCarthy 1997, 2000; Channell 2000; Roberts et al. 2003; Togher et al. 2004), I aimed for an awareness-raising approach, using my experience as a teacher of English as a foreign language to devise tasks which would further this objective. Tasks 1, 2 and 3 (Appendix 5, pages 464-470) are examples of the materials which were used at Practice A.

Task 1, in which the aim was to raise awareness by contrasting receptionists' own perceptions of their opening moves with their actual usage, seemed to me effective for several reasons. First, receptionists enjoyed finding out that their own intuitions were not always correct (see Silverman 1992). Second, they became aware that training cannot be prescriptive (see e.g. Cameron 2000) and that more than one verbal style can be effective. Third, the task led to spontaneous discussion of the appropriateness of different forms of opening (see Erickson and Schultz 1982).

Task 2 was designed with the idea that, by completing a cloze exercise, receptionists would discover and discuss ways of dealing with a problem. This task was less successful, perhaps because, on the one hand, receptionists were not familiar with exercises of this type and, on the other, it was too difficult. Only the reception manager successfully completed the exercise and, while it did lead to discussion of individual features such as the absence of an apology at lines 4-5, it took a long time to complete and led to an uneconomical use of the limited amount of time which was available.

In an attempt to implement the insight of Aston (1995: 80) that teaching needs to focus "on the ways in which things can be worked out when the instantiation of those scripts is problematic for participants in the talk", Task 3 was also designed to improve the approach of receptionists to problem solution. It was even less successful. Not only was the task type unfamiliar, too long and over-challenging but, during the read-through, the pseudonyms and codes used to make the transcriptions anonymous were rendered pointless, when the receptionist who had been involved in the encounter not only recognised herself but also identified herself for her colleagues. This was particularly unfortunate because the example was used to highlight areas where improvements might be made. The lesson for training purposes seemed to be that shorter examples should be selected and, where receptionist performance might be subject to critical appraisal, examples from other practices should be used.

In addition to designing tasks whose impact was limited, at Practice A I also underestimated the preparation time which receptionists would need before viewing transcriptions of their own talk, a problem which was exacerbated by my decision to give 'eye dialect' renditions of non-standard phonological features, an approach which was subsequently changed (see §3.6.1). Several receptionists declared themselves shocked by the amount of 'slang' and 'incorrect English' which they used. These reactions not only revealed that receptionists were experiencing unnecessary discomfort but also showed that the message which I wished to put across regarding the appropriateness of "contextually conditioned variation" (Cameron 2000) had not been assimilated. Changes were consequently made for the sessions at Practices B and C where similar types of task were used. At both practices, rather than being encouraged to tackle language production exercises, receptionists were asked only to discuss data. Task 1 was therefore repeated during both the later feedback sessions but Tasks 2 and 3 were replaced by activities of the type illustrated in Tasks 4 to 6 (Appendix 5, pages 471-473.)

In Task 4 backstage and front stage talk types are contrasted. The main aim here was to draw attention to the formality and the efficiency orientation of frontstage talk by juxtaposing it with the more informal styles of the same speakers backstage. Working in small groups, receptionists at Practice B themselves identified all the features listed below the data in Appendix 5 (page 471) and were given some confirmation of their answers when they later viewed examples of interaction with patients. A subsidiary aim in this task was the development of a group dynamic (see Dörnyei 1997) in the session, both through the reminder which the task gave receptionists of their team rapport and through the enjoyment they experienced when working together on informal data. This paved the way for the more serious discussion which followed in Task 5, which attempts to remedy the errors made in the design of Task 3.

In Task 5, short examples were chosen from encounters in other practices in which the relational practice of receptionists seemed to me in some way inappropriate. These examples were projected onto a screen and comments were invited from the group. At Practice B, this proved much more effective than the method used in Task 3. Receptionists identified the moves labelled and shown in the appendix in bold font as inappropriate and also discussed why the receptionists in question behaved as they did. At Practice C, in contrast, receptionists were unresponsive to this task, seeming to expect more definite guidelines from the training session. This desire for a more prescriptive approach suggested that receptionists at Practice C were unconsciously collaborating with the top-down approach (see Fairclough 1992) taken at their practice.

Task 6 was also used at both Practices B and C. The aim of this exercise was to draw attention to the hesitancy and uncertainty of patients and contrast it with the high levels of fluency and competence among receptionists. This task, in which items were presented in a list, also made little impact, perhaps because the use of uncontextualised examples undermined the advantage to be gained from using transcriptions of naturally occurring interaction, as well as falling into the trap of over-generalisation which Hydén and Mishler (1999) warn against.

As already mentioned (§8.1.1), the training sessions were extremely well received at Practices A and B, where anonymous written feedback from receptionists and practice managers was unanimously positive (see Appendix 6, p.487 for feedback form). The success of the Practice B feedback session was confirmed both by the request from the practice manager for a follow-up study and by the evidence from this later study, which involved the collection and analysis of a second receptionist data-set, that the receptionists who were involved had slightly modified their interactional styles. My brief in the follow-up study was to assess whether the relational practices of receptionists had changed following the computerisation of the front desk filing system, which was thought to have reduced their front desk work load. The follow-up study could not exactly replicate the first, for example because it took place on a different day of the week, when different surgeries were being held, with only three of the receptionists from the first study on duty. However, some observations could be made.

Whether as a result of having more time or more training, the three receptionists who were re-recorded on the return visit seem to have assimilated my message that positive relational practice is important, since, at the follow-up feedback session, they responded more frequently to patients' non-transactional comments with reciprocal relational talk and also seemed more inclined to introduce small talk themselves. What was perhaps more striking was their increased capacity for critical analysis and meta-linguistic comment when examples were presented for discussion. This was revealed in their discussion of the data in Tasks 7 and 8 (Appendix 5, pages 474-475), in which the fine gradations of remedial action shown in the three appointment refusals in Task 7 were recognised and assessed and a rapid distinction was made between the first asymmetry-reducing and the second asymmetry-increasing comments in Task 8.

At this feedback session receptionists were also given examples of different styles of relational practice, some of which are exemplified in Appendix 5 (pages 476-477). In introducing these examples, I suggested that none of the discourse was essential to

the completion of front desk tasks but that, through such talk, the business of the front desk was humanised. In the example of routine politeness and of the use of humour and teasing this was achieved without occupying a significant additional amount of receptionist time. The personal talk with the new mother in the last example does take more time but it occurs in an interactional space which has been created by the introduction of the computer filing system.

My experience at Practice C was completely different. There was low attendance at the feedback session; receptionists were more interested in the ethnographic description of front desk activities than in the discussion of their talk; and the whole session was monitored by the practice manager, who subsequently sequestered the transcripts. There was only one positive comment from a receptionist immediately after the session and I received no written feedback. All of this was unfortunate because, as Channell (2000) shows, and as the response to the feedback sessions at Practices A and B confirmed, it is receptionists themselves who understand the needs and problems associated with their work and training is likely to be more successful if their expertise and awareness is taken into account. The lack of interest in the feedback session at Practice C, which had an almost identical structure to the one at Practice B, also seems to confirm Channell's view that receptionists should be involved in a project of this type at all stages, since the apparent feeling of the Practice C receptionists that they were on the receiving end of the research rather than being fully involved in it (see§8.1.1) seems to have led to a detachment from the whole research process which extended to the session which was specifically designed for their benefit. In other words, they had no sense of involvement or ownership and experienced the study as research *on* rather than *for* or *with*, as was intended (see §3.1.6).

8.3.2 Recommendations for receptionist training

The four feedback sessions described in the previous section are all to be seen as work-in-progress since they were held before my analysis was complete and, thus, before my ideas were fully defined. They were also fairly hastily prepared and

generically hybrid, since they combined feedback and training. There were nevertheless insights to be gained from them. First, it should be remembered that receptionists belong to a different disciplinary culture from applied linguists (see §3.1.5) and should not be plunged into dealing with unfamiliar material. Second, very great care should be taken to avoid exposing individual receptionists to public analysis of their performance (see §3.1.6). Third, when research is combined with training, the target groups of receptionists should be involved in the research at all stages. Fourth, if properly designed and presented as I believe that, for example, Tasks 1, 4, 5, 7 and 8 were, awareness-raising tasks can be very successful. Receptionists are capable of incisive analysis of both their own discourse and that of other receptionists and are open to improvement of their own performance, as one would expect from a group of people who often claim that they have entered the profession because they wish to help people (see §2.1.2).

In order to address the areas of receptionist practice which, it seems to me, require scrutiny, it will also be necessary to target materials more carefully on chosen areas, highlighting lapses in professionalism, showing that the efficient accomplishment of transactional goals can be combined with interpersonal attention, that formulaic apologies can easily be issued when service provision fails, and that there are alternatives to the routinisation and formality which are most characteristic of front desk interaction. Finally, receptionists can be made more aware of the power which they hold and of benign ways of exerting it.

8.4 Future directions

In this study broad coverage has been given to many features of front desk discourse, which it would be desirable to investigate in greater detail. For example, the speech acts used to complete Information Check, Confirmation and Resolution stages and their relational implications could be analysed with the same attention given to those used for Service Orientation. Detailed knowledge in this area might be of some value, for instance, if automated voice systems are developed to deliver reception services. In addition, although detailed profiles are provided of the different

receptionist enactments of service bids, it would also be useful to relate these to the performance in subsequent stages by the same individuals, in order to observe whether relational styles are consistent, as intimated in this study, or fluctuating. Close attention to the talk of individual receptionists might also include further analysis of phonological variation in order to identify patterns of convergence and divergence, which would in turn shed further light on the positioning of participants and, in order to foster greater understanding between receptionists and patients. If data were to be collected in other sites and regions it might also be possible to determine whether the communicative styles identified in this study are typical of the discourse of GP receptionists and patients in Great Britain and to make another attempt to record the telephone calls in which appointments are made.

One of the main goals of the study was to produce an analysis which would be of social value and to share the findings, not only with the participating practices, but also with the wider community concerned with health communication. Ideally this would be achieved through increased collaboration with healthcare professionals, the development and dissemination of training materials and consultancy work with interested practices. In order for any such training to be successful it would be necessary to continue to develop awareness of how the shifting ideologies of health care provision are reflected in receptionists' talk and to refine understanding of how their relational practices construct power asymmetries of the type observed in this study. This would involve, for example, further detailed examination of problematic encounters, including those between receptionists and patients from other cultures, as well as contextualised analyses of remedial action. It would also be useful to integrate etic and emic perspectives on front desk work and to find additional means through which these can be applied in receptionist training.

8.5 Conclusion

The front desk of a GP practice is an institutional site which most of us visit at some stage in our lives. This research has shown that, whatever the social context of the front desk encounter, both receptionists and patients tend towards a task focus rather

than furthering the development of interpersonal understanding or drawing on the wider identity resources available to them. However, it also seems that receptionists who have received more training incorporate the development of relational practice into their understanding of the receptionist role, thus enhancing both their own experience and that of patients. It is to be hoped that the findings from this research can be used in future training programmes and so contribute in a small way to improving the front desk experience both for ourselves, the patients, and for the receptionists who facilitate our entry into the health care system.

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APPENDIX 1

Transcriptions of audio recordings

Transcription conventions

?	rising intonation
↑	marked rising intonation
↓	marked falling intonation
!	exclamatory intonation
.	pause between tone groups
(.)	pause of less than one second
(2)	pause timed to nearest second
::	each colon indicates further lengthening of a sound
<u>no</u>	underlining indicates a stressed word or syllable
no	bold font indicates a word spoken louder than those around it
pres-	a dash immediately after an item indicates that the speaker has broken off before completing the utterance
‖	double slashes on successive lines indicate the beginning of
‖	overlapping speech
=	indicates that there is no gap between speaker turns
=	
11-11	indicates the time on the mini-disc counter in minutes and seconds
{mhm}	curly brackets enclose utterances made during another speaker's turn
(*sighs*)	italicised text in round brackets indicates either contextual information or non-verbal vocalisations
(?text)	regular font preceded by a question mark indicates a guess
hh	indicates laughter unit

Initials have been used for the names of patients, streets and towns but, in a small number of cases, pseudonyms have been used to ensure clarity.
Receptionists and doctors have also been given pseudonyms.

Coding system for participant information

Participant codes

RA1:	the first (1) receptionist (R) in the data from Practice A (A)
PC47:	the forty-seventh (47) patient (P) in the data from Practice C (C)
AR:	assistant receptionist
CR	community receptionist
PM:	practice manager
IA:	independent adviser
HH:	Heather Hewitt
NCP	non-consenting patient

Patient information

F/75+/lw/om: sex/age/last attendance/ attendance pattern (see below)

Sex: F - female; M - male

Age bands: 16-25; 26-40; 41-60; 61-75; 75+

Last attendance at practice:

y	yesterday	……
lw	in the last week	……
lm	in the last month	……
ly	in the last year	……
o	other	……

Attendance pattern:

ow	once a week	……
om	once a month	……
esm	every six months	……
ey	every year	……
o	other	……

Practice A, Disc 1: 9 a.m., Monday 16th December 2002

00-01 **F/41-60/lm/esm**

PA1: is that different frae this? (*referring to consent form and questionnaire*)

RA1: it's Dr Brown . just a wee second . I'll book y'in (*P1 coughs*) (2) that's fine . it's room seven for you . just take a wee seat B (*woman's first name*) and

00-08 she'll call you (.) kay?

00-16 *RA1 asks ARA1 if she can get a prescription signed by a GP*

00-30 **M/16-25/lw/ey**

RA1: hi there

PA2: hi there I'm . my name's R J . I've got blood tests at ten past nine

RA1: blood tests with the nurse that'll ↑be (4) R J

PA2: yep

RA1: that's fine . can I just give you one of these R? (*man's first name*) (*gives questionnaire to PA2*) (1) there you ↑go

PA2: thanks (2/3 words unclear)

00-46 RA1: the nurse'll call you . okay?

00-47 *HH checks the numbering system on the questionnaires with RA1.*

01-01 *ARA1 checks that RA1 has got a house call organised.*

01-04 *The community receptionist confirms that RA1 has checked in one of her patients.*

01-33 **F/41-60/o/o**

ARA1: Mrs C? (*calls patient to collect prescription*)

RA1: (2) okay?

PA3: || thanks hen

RA1: || your other one'll be ready Wednesday

PA3: I'll get it on Wednesday?=

RA1: =yeah

PA3: thanks very much=

RA1: =okay . <u>no</u> problem . thanks . bye

01-42 PA3: bye:

01-46 *RA2 checks with RA1 that some papers have arrived*

02-40 *Phone rings 2¼ times. RA1 arranges emergency appointment.*
Phone rings twice

03-30 NCP

03-37 *Phone rings twice.*

03-52 *Practice manager greets RA1.*

03-54 *RA1 comments to HH on cold.*

04-02 *Phone rings 3 times. RA1 asks caller to hold.*

04-08 *Phone rings 3 times. RA1 arranges appointment.*

05-56 *RA1 apologises for keeping caller waiting. Phone rings 5 times.*

06-09 **F. No details.**

RA1: hi there . can I help you?
PA4: can I have an appointment for today? (.) (?also) (*ARA1 can also be heard giving prescription to* NCP)
RA1: are you looking for one?
PA4: yes
RA1: ten past twelve?
PA4: lovely
RA1: what's the name?
PA4: T N (*phone rings 7½ times*)
RA1: (4) T (*woman's first name*) . 7-2-71 T . okay that's ten past twelve for you . okay . excuse me . excuse me T (.) oh no . okay (.) you'll get one of these
06-33 (*questionnaire*) when you come back . okay?

06-35 *Phone. RA1 asks caller to hold.*

06-40 *Phone. RA1 arranges house call.*

08-20 **F/61-75/ly/esm**

PA5: (*low voice*) morning
RA1: hi there
PA5: I've an appointment with Dr MacLaverty at quarter past ‖ nine
RA1: ‖ Dr MacLaverty at quarter past =
PA5: = twenty past nine . sorry=
RA1: =can I give you that form please (*questionnaire*). what's your name?
PA5: I R
RA1: that's fine . room four for you I (*woman's first name*){PA5: right} s- just take a wee seat ‖thank you
PA5: ‖ have I to take this ‖ in to the doctor?
RA1: ‖ just take that in with you . have a look 8-
31 at it . aha . thank you

08-32 *Phone rings 3 times. RA1 arranges emergency appointment.*

09-08 **M. No details.**

RA1: hi there
PA6: I'm wanting an appointment to see a doctor
RA1: you're wanting an appointment
PA6: aye
RA1: when for?
PA6: er . just . whenever
RA1: and is it anyone in particular?
PA6: no

RA1: no (2) for any day: this week D (*diminutive form of man's first name*) you'd need to phone at quarter past . eh . half past three . that's when the computer releases more appointments for each d- . day . you know . the following day . other than that we're looking (.) maybe a week ahead {PA6: aye} what do you prefer to do?
PA6: er (.) I prefer it this week
RA1: you prefer it this week?
PA6: aye
RA1: if you could give us a call (.) maybe half past three today for tomorrow then
PA6: (.) right
RA1: or . if you don't get anything then phone me at half past eight in the morning for an on-the-day appointment {PA6: alright} see what we can do there
PA6: right . is the phone number on these cards?
RA1: it'll be on the card . it should be D . aha
PA6: right . okay
RA1: is it one of these wee ones you've got?
PA6: aye=
RA1: =aye . it's there on the . there on the front with the stamp . okay?
PA6: on the front with the || stamp?
RA1: || have you got it? no:? (1) take one
PA6: right thanks (.) that's half past three
RA1: phone at half past three D || aha
PA6: || right . thanks
09-56 RA1: bye

09-56 *Phone. RA1 arranges appointment.*

10-51 *Phone. RA1 speaks to patient who is checking appointment details. Patient hangs up mid call.*

11-27 *Phone rings twice. RA1 arranges house call.*

12-40 *RA1 tells ARA1 about house call.*

12-46 NCP

13-10 **M. No details.**
RA1: hi <u>there</u>
PA7: hiya
RA1: whoops (*ARA1 deals with PA7's prescription request while RA1 talks on phone*
13-46

13-18 *Phone rings 3 times. RA1 arranges for a doctor to call a patient.*

13-53 *Husband of RA1 calls in to collect some keys.*

14-00 *RA1 tells HH that visitor was her husband.*

14-32 *RA1 tells ARA1 that documentation has been completed for house calls.*

14-35 *Phone rings 1½ times.*

14-45 **M/61-75/lm/om**

PA8: mair rigmarole (*refers to consent form and questionnaire*)
RA1: ha ha ha ha ha ha (1) more paperwork eh?
PA8: || aye
RA1: || ha ha ha ha . thank you
14-52 PA8: right darling . thank you

15-54 **F/41-65/im/om**

RA1: (*coughs*) thank you (.) do you have an appointment?
PA9: aye . with Dr Brown
RA1: with Dr Brown . what's your name?
PA9: D M (*woman's name*)
RA1: D M that's fine D (*woman's first name*) nine twenty . Dr Brown . room seven .can you take that one <u>for</u> me? (*hands out questionnaire*)
15-07 (.) thank you

15-08 *Phone rings 3 times. RA1 arranges for a doctor to call patient.*

16-06 *HH checks that research isn't interfering too much with RA1's work.*

16-25 *RA1 asks ARA1 to give something to doctor.*
ARA1 and HH joke about involvement of former in research.

16-54 – NCP

17-00 (*phone rings 3 times*) (*RA1 coughs*) oh dear

17-09 *Phone. RA1 arranges emergency appointment.*

17-40 RA1: (*coughs loudly*) oh . this is terrible . mmmh . excuse me

---

17-47 *Phone rings seven times. RA1 confirms appointment time.*

18-01 *RA1 talks to HH about a cough and cold sores which she can't get rid of.*

19-11 **F. No details.**

RA1: are you okay there? . can I get that for you? (*prescription*)
PA10 yes please . (?mm . yeah)
RA1: (1) this one –ha ha ha
PA10: will that . will that be . this . in one or two days yes?
RA1: two days . aye . is that okay? || or are you desperate for it?
PA10: || yeah . it's just that I was actually supposed to get an injection tomorrow and I forgot I didnae have any but em . I'll see if I can get another appointment with the nurse (several words unclear)
RA1: I can ask for it this afternoon if it's urgent for you
PA10: er . that would fi- . if you could do that . yeah . that be great (2) when will I know that?
RA1: (1) it should be okay
PA10: it should be
RA1: if you leave it to late afternoon . maybe about four? || is that okay?
PA10: ||now that's (.) that's smashing || then I'll be gone in to B (*town nearby*) later on today . that be

RA1: || will I get that done?
PA10: great
RA1: okay I'll get that done for you || okay?
PA10: || that's great . I'll not need to change the other appointment now || thanks a lot
19-52 RA1: || that's right . okay then . thank you . bye:: (*coughs*)

20-38 **M/61-75/lm/om**
RA1: good morning . hi there
PA11: morning
RA1: thank you (*takes consent form*) || can I help you?
PA11: || e::h (.) I've got a prescription for eh . M P (*woman's name*)
RA1: got a prescription . do you have an appointment?
PA11: (.) and I've got one of them and all {RA1: right} with Dr MacLaverty
RA1: can I give you that form to (.) fill in please (*questionnaire*)
ARA1: what's your name?
PA11: A P (*man's name*)
RA1: A P . there you go
ARA1: eh . what's the address Mr P?
PA11: five four E Court
ARA1: there y'are (*gives out prescription*)
RA1: okay . that's Dr MacLaverty room four . just take a wee seat (.) || okay
PA11: || right (.) I've got to fill this in have I?
RA1: yes please
PA11: have you got a pen?
RA1: || yep . there's one up there for you
21-05 ARA1: || there's one here for you

21-09 NCP

22-03 PA11: what do I do with this hen? (*completed questionnaire*)
RA1: (1) just put it in the box for you – okay?
PA11: I never noticed that
22-13 RA1: that's fine . okay . haha . thank you

22-14 *RA1 checks with HH that her instruction to PA11 was right.*

23-10 *Phone rings twice. RA1 explains to HH that it's not for her.*

24-12 **F/41-60/lw/ey**
RA1: hi there (.) can I help you? . do you have an appointment?
PA12: I have an appointment . aha
RA1: what's your name?
PA12: I K (*woman's name*)
RA1: (.) I K=
PA12: =it's for Dr Mertoun
RA1: (2) I K . that's room one I (*woman's first name*). can I give you this form to fill in please (*questionnaire*) || thank you
PA12: || oh right . thanks . do you want it back? . aha?
RA1: it just goes in the box
PA12: oh right || right

24-30 RA1: || okay

24-37 *HH checks with RA1 that consent forms and questionnaires are being*
24-47 *correctly numbered. Phone rings twice.*

24-24 *Phone rings 3 times. RA1 arranges appointment with telephone surgery.*

26-24 *Phone rings 4 times. RA1 arranges appointment.*

27-30 **M/26-40/lm/esm**

RA1: morning . can I help || you?
PA13: || aye . got an appointment for Dr Brown . half nine
RA1: got one for Dr Brown at nine thirty . what's the ↑name?
PA13: R D (*man's name*)
RA1: (3) R D . that's fine . that's room seven for you . and can I give you that form to complete || thanks
PA13: || right . have you got a: . my wife's prescription there. E D?

27-48 (*ARA1 deals with query)*

27-52 NCP

28-36 PA13: can I leave you that? (*questionnaire*)
28-42 RA1: e:h . have you completed it? . that's fine . I'll just put it in the box for you

---

29-24 *GP asks RA1 when GP colleague is going on holiday.*

29-58 NCP

30-09 **F/61-75/lm/esm**

RA1: hi there
PA14: hi . I've got an appointment with eh . eh . the nurse this morning for my cholesterol (.) er K J (*woman's name*) =
RA1: =K J
PA14: is that okay?
RA1: that's fine . eh . just take a wee seat and she'll || call you
PA14: || right y'are || er . thanks .
RA1: || can you manage there?
PA14: I've never done this before (*attached sticker to repeat prescription*)
RA1: have you no? (.) right . no || I'll get it off for you
PA14: || you take these off?
RA1: that's right . stick it on . that's right
PA14: oh do you? || and what do you do noo?
RA1: || yeah
I'll take them from you
RA1: || that's after two on Wednesday
PA14: || he usually does it
RA1: thank you . after two on Wednesday . okay?
PA14: (3) oh . and I've to give you that (*consent form*)

RA1: okay right . ha ha ha . and can I give you ‖ this one? (*questionnaire*) . a fair swap

30-37 PA14: ‖ ha ha . thank you

31-23 NCP

31-36 *Prescription handed in*

31-37 NCP

32-01 *Phone rings 4 times. RA1 advises patient to call at 3-30 for next day appointment.*

32-36 **F/ 61-75/lm/ om**

RA1: hi there
PA15: eh . R S (*woman's name*) for Dr Brown
RA1: Dr Brown
PA15: (4) I think it's nine forty
RA1: (.) it <u>is</u> . that's <u>you</u> it's room seven . and can I ask you to fill in that wee form
32-50 for me? (*questionnaire*) . it just goes in this box when you've done it thanks

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33-27 RA1: thank ↑you (*PA15 puts completed questionnaire in box*)

33-33 *RA1 asks ARA1 if she needs house call book.*

33-38 RA1: (*coughs*) excuse me (*coughs*) excuse me
(*coughing can also be heard in waiting room, like an echo*)

33-58 RA1: scuse me (*phone rings 2½ times*)

34-07 RA1: is Elizabeth (*CR*) attending to you? (*to P waiting at community reception point*)

34-28 *Phone rings 1¼ times. RA1 advises patient to call at 3-30 for next day appointment.*

34-59 NCP

39-38 RA1: (*to ARA1*) got a doctor handy?

39-50 **F. No details.**

RA1: hi there
PA16: hi . I've done a really silly thing . I- . I've run out (.) of my (name of drug)
RA1: (.) you've run out of it?
PA16: yeah . could I g- . is it . I had one left for this morning . could I get it?
RA1: what . this one?
PA16: e:hm . <u>aye</u> . is there any chance of getting it ‖ this afternoon
RA1: ‖ I'll have a look at it for you
PA16: I thought I had a ‖ strip (*scrip/prescription*) left
RA1: ‖ is that
is that two items you're needing?
PA16: aha . aye . no so much (name of drug) . I've got enough
RA1: (.) fourteen nine forty-nine . that's <u>you</u>

PA16: that's it (1) I thought I had a strip left . I've got a funny feeling that when || I've (several words unclear)
RA1: || such a busy time eh . we're forgetting things || these days
PA16: ||oh I know (1) I think I must've thrown it out {RA1: aha} with the empty (.) || strips
RA1: || aha . okay . the cream has to go to the doctor || so I cannae dae that one . okay?
PA16: || aye that's - aye that's fine
RA1: now that's your other one coming off: (.) do you want to take a wee seat and we'll see if we can get it signed for you
PA16: oh that would be brilliant thanks
40-44 RA1: okay

40-47 NCP

41-16 *Phone rings twice. RA1 apologises for taking call meant for RA2.*

41-25 RA1: (*coughs*) excuse me

41-30 **F. No details.**
PA17: does this just go in here? (*consent form mistakenly returned to box for questionnaires*)
RA1: it does . that's it . thanks Mrs B
PA17: (10) that's it . ta
41-43 RA1: thank you very much . thanks

41-44 *RA1 asks ARA1 if she could find a doctor to sign prescriptions.*

41-58 **F/41-60/ly/o**
RA1: hi there
P18 hi . Dr Mertoun for nine (.) forty?
RA1: what's the name please?
PA18: D M (*woman's name*)
RA1: that's fine D (*woman's first name*) . that's (.) room one . if you can just take a wee seat and can I give you that form as well || please
42-07 PA18: || okay . thanks

42-11 *RA1 and ARA1 discuss prescriptions and house calls.*

42-20 *Prescription handed in.*

42-23 *Prescription handed in.*

42-28 *Phone rings 3 times. RA1 arranges appointment.*

43-18 RA3: is anyone just waiting to collect a prescription?

43-38 **F. No details.**
RA1: hi there
PA19: can I make an appointment for the doctor please {RA1: aha} I think it's Dr Mertoun . || they said they'd a letter out . the nurse
RA1: || you're looking for-
you're looking for Dr Mertoun?

PA19: aha . the nurse told me they'd a letter out
RA1: aha . I'll just check for you (.) actually I've no got anything coming up for him just now . he's actually going on holiday (.) can anyone else help you?
PA19: aye .‖ anybody . I'm no (?bothered)
RA1: ‖ anybody else?
er: . try Dr MacIntyre
PA19: that's fine . aye
RA1: (3) I can give you Dr MacIntyre on Thursday at twenty to four
PA19: that's fine
RA1: is that okay for you? what's the name?
PA19: M R (*woman's name*)
RA1: R (*surname*) (2) and your date of birth M (*woman's first name*)
PA19: one nine forty-one
RA1: (1) one nine forty-one (.) is that 64 B Road?
PA19: that's right
RA1: okay (.) I'll give you a wee note of that (.) that's Thursday the nineteenth (4) at fifteen forty (.) that's Dr MacIntyre (3) ‖ okay?
PA19: ‖ that's lovely (.) fine thank you
RA2: ‖ don't give out appointments for Dr MacIntyre (.) **stop** (*shouted through from back in strangulated voice*)
44-26 RA1: ba-bye

44-32 **M/26-40/lw/o**
RA1: oh . I've just given one (*responding to RA2*) (.) too late (*PA20 laughs*) hi there
PA20: gie you that first (*consent form*)
RA1: I just gave one (*appointment*) . there that minute (*PA20 laughs*) just . that . minute . she was too late . ha ha ha . you've got an appointment <u>for</u>
PA20: Dr Mertoun (.) P G (*man's name*) the-=
RA1: =Dr . Mertoun?
PA20: yeah
RA1: (.) today . er
PA20: (1) nine fifty or something
RA1: P G?
PA20: that's the one
RA1: that's fine . just take a wee seat ‖ then could you
PA20: ‖ right
RA1: (.) okay and could you fill that form out ‖ for me . thank ↑you
44-55 PA20: ‖ yeah . will do

45-00 46-02 *Phone rings 3 times. RA1 advises patient to phone at 3-30 the next day to get an appointment with a female doctor.*

46-05 *Phone rings 12½ times. RA1 asks patient to hold.*

46-10 NCP

46-20 *Prescription handed in.*

46-24 NCP

47-02 *Phone rings again. RA2 apologises for keeping patient waiting and refers her to practice nurse.*

47-31 *Phone rings nine times. RA1 arranges house call.*

48-46 **M. No details.**

RA1: hi there (*consent form handed in*) (1) ‖ thank ↑you

PA21: ‖right (.) see that number two there {RA1: aha} that should be one <u>three</u> times a day . he's got one <u>five</u> times a day

RA1: (1) right . that's really the doctor that has to change that . I cannae do anything about that=

PA21: =aye well . that's ‖ what it is

RA1: ‖ are you ordering these?

PA21: aye I'm ordering em (.) aye

RA1: so what you're saying is this should be one . <u>t</u>hree times a day?

PA21: (.) aye (.) mhm (1)

RA1: ‖ I'll just put a wee note

PA21: ‖ it was the thing that pullt me up the last time I got it {RA1: aha} along at (.) the chemist

RA1: should be <u>one</u> . three times a day

PA21: right

RA1: okay that's a wee note on it {PA21: right} doctor'll see that

PA21: ‖ okay then . thanks

49-24 RA1: ‖ thank you then . ba-bye

49-25 *RA1 calls after patient whom she has forgotten to give questionnaire.*

49-29 **F. No details.**

RA1: hi there

PA22: hiya . just to hand that <u>in</u> . she says to gie you that as well (*consent form*)

RA1: (.) and have you got a prescript- . you've no got an appointment . sorry

PA22: no . just handing that in

RA1: okay then . thanks (?P) (*woman's name*)

49-38 PA22: bye

49-37 *RA1 checks with HH on when to hand out questionnaires.*

49-43 NCP

49-50 RA1: is that somebody hanging on? (*looks at monitor on telephone*) (.) no . sorry

49-54 Eileen (*ARA1*)

50-15 *Prescription handed in.*

50-23 **F. No details.**

RA1: hi there (1) thank ↑you (*consent form handed in*) ↓thank you

PA23: hi:

RA1: (.) do you have an appointment?

PA23: no I have not .

RA1: ‖ you haven't got

PA23: ‖ it's just for to pick up a prescription for R C (*man's name*)

RA1: okay: . leave it with me and I'll get it for you

ARA1: R C?

PA23: aha . and er . it- . no . I'm sorry it's for myself . it's for C C (*woman's name*) hha
ARA1: alright ha ha ha
PA23: sorry about that . and I was wondering if there's any appointments for this Thursday for the: . wart clinic
RA1: (1) this Thursday?
PA23: aha
RA1: (*phone rings*) (2) there isnae one today . eh this Thursday . actually
PA23: erm
50-54 RA1: hold on a wee second (.) please

51-00 ARA1: give me your address C (*woman's name*)
5-02 PA23: 61 B Drive (.) thank you (*takes prescription*)

50-54 *Phone rings 4 times. RA1 arranges emergency appointment.*

51-30 RA1: you're looking for: . a wart clinic appointment isn't it?
PA23: aha (.) please
RA1: (24) right (.) could you try again maybe the (.) nearer the end of the year because {PA22: aye} there's no one made up for January yet . okay?=
PA23: =that's fine (6) (*sorts self out before leaving*) kay tha:t's fine (.) thanks
RA1: okay?
PA23: right
52-14 RA1: thank you . ba-bye

52-15 **F/61-75/lm/esm**
PA14: eh . can I make an appointment for the doctor please?
RA1: what's the name?
PA14: er . K J
RA1: anybody in particular?
PA14: no:
RA1: no?
PA14: no really
RA1: right . for any day this week what I'd need to ask you to do is phone at half past three when the computer releases the appointments for the <u>next</u> day
PA14: oh aye
RA1: other than that ‖ we're looking (.) at the ↑following week
PA14: ‖ mhm . so phone every day at half three?
RA1: phone at half three for to<u>morr</u>ow . tomorrow for Wednesday etcetera {PA14: mhm}or I can look ahead to next week if you want (.) or would you prefer
PA14: e::h
RA1: to <u>try</u> for ‖ this week
PA14: ‖ we:ll . have you got <u>any</u>thing next week – **hiya** (*to another patien*t)– in ‖ er female . anything
RA1: ‖ I might have got . (?just a wee second) . have a look at Thursday (6) no I havenae
PA14: no it disnae matter ‖ I'll just phone every day
RA1: ‖ er:m . <u>sorry</u> I'm just checking to see {PA14: (?aha)} thought I had one there but (.) it's not (7) I've got <u>Fri</u>day {PA14: mhm} I can give you half past three with Dr C- . er half past one sorry . with Dr Carrington (*locum?)*
PA14: that's lovely thanks=

RA1: =is that okay <u>for</u> you?
PA14: mhm || that's <u>this</u> Friday?
RA1: || K J
PA14: yeah (2) one thirty?
RA1: 6 H Valley . that's you=
PA14: =that's right . aye
RA1: that's one thirty on Friday the twentieth || have you got that okay? Dr Carrington
PA14: || that's (.) that's lovely . thank ↑you
RA1: thanks then . ba-bye
53-21 PA14: thanks very much . bye-ee

53-23 NCP

53-28 **F. No details.**
RA1: **M** (*woman's first name*) (*shouts into waiting room for patient who comes up to collect prescription now signed by doctor*) (4) sorry to keep you waiting . I just couldnae quite get || to shout on you there
PA24: || its'alright . as long as I get em . that's alright
53-38 RA1: that's okay then (.) thanks . bye (1)

53-40 NCP

54-09 *RA1 whispers something to HH, who laughs.*

54-14 **F/61-75/lm/esm**
PA25: e:h || M (*woman's first name*) R- (*breaks off after first letter*)
RA1: || morning
PA25: (*fast*) morning . MR (*woman's name*) . e:h . Dr MacLaverty
RA1: (7) there we go . that's room four for you ↑M . okay? (2) ↑swap you || ha ha . you take that one . thank ↑you (*questionnaire for consent form*)
PA25: ||ha ha aye he he
54-31 thanks

54-37 *Prescription handed in.*

54-41 *ARA1 asks RA1 for help in sorting out a problem relating to two*
54-51 *prescriptions.*

54-53 *Phone rings twice. NCP arrives.*

55-01 *Discussion about prescriptions continues.*
Phone rings.

55-20 **M/61-75/ly/o**
PA26: hi<u>ya</u> (1) I'm looking for a questionnaire
RA1: (.) yeah . here we <u>go</u> (1) do you have an appointment Mr R?
PA26: no
RA1: no (.) okay then (.) thank you
PA26 (*several words unclear*)
RA1: || eha ha ha
55-33 ARA1: || ha ha ha

55-33 *AR1, R1 and HH all start talking. R1 explains to HH that PA26 is on the local council. HH remarks that he's a well-behaved patient. ARA1 and SA1 continue to work on prescription problem*)

55-54 *Phone rings 4 times. RA1 puts the doctor who is calling through to a practice GP.*

56-30 ARA1: think I'll go for a coffee (.) ten o'clock

56-37 **F/41-60/lm/om**

Phone rings twice

RA1: morni:ng
PA27: morning
RA1: thank ↑you (*takes consent form*) (.) do you have an ↑appointment?
PA27: it's actually the nurse I want to see
RA1: right (.) I can book you in though
PA27: right
RA1: what's your ↑name?
PA27: M M (*woman's name*)
RA1: (1) M M (.) can I give you a wee form here M (*woman's first name*) just to fill in for us? (*questionnaire*) (1) thank you
PA27: thank you
RA1: pen there . there's one up there for you if you want

56-55 PA27: okay

57-03 *Phone rings once. RA1 arranges double appointment for later in the week.*

58-12 *AR1 offers HH and IA1 a cup of tea*

58-25 *Tea break and consent form discussion between RA1, ARA1 and HH.*

59-16 *Phone rings once. RA1 gives out number to call for health visitor.*

59-30 RA1: (*coughs*)

59-44 *RA1 and HH discuss RA1's throat problem and aspects of research.*

60-36 NCP

61-04 *Further discussion between RA1 and HH of RA1's throat problem.*

61-24 **F. No details.**

RA1: ↑morning
PA28: morning (.) e:hm
RA1: (*very fast*) can I help you?
PA28: is ma:: prescription in? (.) AC (*woman's name*)
RA1: C (*echoes surname*)
PA28: (1) it was Friday morning I put it in
RA1: probably after two t- . oh there we go! . ha . wait a minute || hit it lucky
PA28: || that's fine (.) that save me coming back
RA1: 13 L Road || is that you?

PA28: || aha . that's it
RA1: okey dokey=
PA28: =right
RA1: thank you . ba-bye
61-45 PA28: bye

61-46 *Phone rings 3 times. RA2 offers HH and IA tea.*

62-33 RA1: (*coughs*) excuse me

62-59 *RA2 asks HH what to do with consent forms and questionnaires.*

63-12 NCP

63-16 RA1: see you in the staffroom then

63-17 *HH explains to RA2 that only patients who give consent are being recorded.*

64-17 *Phone rings twice.*

64-27 *RA2 (reception manager) discusses computer problem with RA4 and explains to HH that practice is fairly quiet, at least when compared with Monday mornings.*

64-53 *Phone rings once. RA2 transfers caller to RA4.*

65-10 *Phone has rung three times. RA2 arranges appointment.*

65-55 *RA2 and HH discuss a cake recipe.*

66-42 *Phone rings 5 times. RA2 tells patient to ring the next day at 3-30 for an appointment.*

67-19 **F/61-75/today/om**
RA2: ↓ mo:rning
PA29: morning . I've to give this to you (*consent form)*
RA2: right . right . I've to give . you . this (*questionnaire*) (1) okay?
PA29: and I have to fill this in?
RA2: yes . after you've seen the
PA29: (.) the doctor
RA2: the doctor . okay?
PA29: right . em . my appointment's for ten past ten || for Dr MacLaverty
RA2: || ten past ten . okay:
(*phone rings twice*) (5) Mrs H? (*woman's name*)
PA29: aha
RA2: it's room four . if you have a seat she'll . he'll call your name
67-44 PA29: right . thank you

67-45 *Prescription handed in.*

67-55 **M/75+/lm/other**
RA2: ↓mo:rning (1) right (*takes consent form*) . || Mr McD

PA30 || I've an appointment with somebody (.) twenty past ten

RA2: I will just check so can you (2) complete that (*questionnaire*) when you have a minute after you come out . okay? . and then you put it in the box

PA30: yeah

RA2: e: m: . ten thirty?

PA30: ten <u>twenty</u>

RA2: (.) oh . ten twenty Mr McD . it's Dr MacLaverty . and it's room four . if you have a seat . okay::?

68-19 PA30: thank you

68-20 *Phone rings 8 times. RA2 confirms appointment time.*

68-58 *Prescription handed in.*

69-09 *RA2 comments to HH that CR has "an awkward customer".*

69-24 *Prescription handed in.*

69-39 *PM and RA2 discuss how they could make IA1, who is sitting near the practice door where she is exposed to cold draughts, more comfortable.*

69-53 **M/41-60/lw/ew**

PA31: good morning

RA2: good morning . yeah (*to PM*) . Mr . McN . and if you take one . take one of <u>these</u> || take one o' these (*questionnaire*)

PA31: || ye:s . I'm just gonna put some lines in

RA2: (.) as well

PA31: thank you dear

RA2: and put it in the box when you've || (.) completed it

P31 || oh . I was going to put the tabs on myself then

70-03 RA2: that would be okay

70-05 *Further discussion of IA1's situation by RA2 and PM.*

70-23 PA31: is that alright dear . thank <u>you</u> (*passes over prescription requests*)

Practice A, Disc 2, Track 1: 10-05 a.m., Monday 16th December 2002

00-00 *RA2 tells IA1 how to get to staffroom.*

00-07 **M/41-60/lw/ow**

PA32: er || I've to give you this I think (*consent form*)
RA2: || hi there . oh ye::s . and I need to get you to (.) swap one for one (*questionnaire*) || if you can put it
PA32: || one for one
RA2: in the box || please
PA32: || I'll do that . yes (1) eh . could I get an appointment with the (.) telephone surgery (.) please
RA2: today?
PA32: aye. || please
RA2: || no problem (5) (*phone rings twice*) that'll be Wednesday afternoon for your ↓prescription
PA32: aha
RA2: (1) and who's it for?
PA32: oh sorry . it's for my wife || it's for S-
RA2: || for your wife
PA32: S B (*woman's name*) yeah (.) 28 (.) R Crescent
RA2: (1) telephone number?
PA32: (*gives number*)
RA2: (*repeats second half of number*)
PA32: someone'll call || at (.) or after
RA2: || between twelve and one?
PA32: between twelve and one . yes
RA2: right
PA32: thanks for your help
RA2: and . you've got an appointment Mr (.) B – no? you've not got an appointment today?
PA32: no || that's it
RA2: || no? . you're just handing in your scrip`
PA32: yeah
RA2: okay . and if you could complete this before you go out the door that'd be lovely
PA32: I'll do that . yeah
RA2: thank you

01-00 PA32: right . thanks

Practice A, Disc 2, Track 2: 10-40 a.m., Monday 16th December 2002

00-00 *RA1, RA2 and CR discuss artificial Christmas trees which they are buying.*

00-51 **M. No details.**

PA33: have I to sign the message? . no? (*consent form*)

RA2: yes . just one moment . I'll give you one (*questionnaire*) (.) there we go . and it's a repeat scrip . kay? (*slowly*) that'll be Wednesday afternoon after two

PA33: is there one for eh (*phone starts ringing*) for (1 word unclear) K. M K (*woman's name*) please

RA2: K?

PA33: yes thank you

RA2: (5) em . what's your address?=

PA33: =one seven five F Road

RA2: (1) there we go

PA33: (.) thank you

01-16 RA2: thank you

01-25 *Phone rings 8 or 9 times. RA2 asks caller to hold on.*

01-32 NCP

01-52 **F/16-25/lm/om**

RA2: okay . thank you (1) I'll just swap and give you one of these (*questionnaire for consent form*) (1) lovely . and have you got an ↑appointment

PA34: aye. A L (*woman's name*)

RA2: right (1) (*sniffs*) it's eh . Dr Brown and it's room seven . if you have a seat . okay?

02-04 PA34: right . ta

02-06 *Phone rings 9 times. RA2 puts caller through to doctor.*

02-15 *Phone. RA2 undertakes to pass on message from caller.*

03-03 *Phone. RA2 arranges appointment.*

03-33 *Prescription hand-in.*

03-48 *RA2 shouts through to back about Christmas tree.*

04-04 *Phone rings 6 times. RA2 asks caller to hold.*

04-09 **M/41-60/lm/om**

RA2: I'll take that form from you (*consent form*) and I'll (.) give you one of these (*questionnaire*) (1) thank you . do you have an appointment?

PA35: no: (.) have I to fill in is it . this in ‖ the now?

RA2: ‖ aha . just now yes . ye:s

PA35: ‖ have you got a pen?

RA2: ‖ or . after you've done all your bits and bobs ‖ yes

PA35: ‖ yeah . yeah . yeah . th- . I could sit down and do it

RA2: yes . aha
PA35: right (1) it's in . eh (.)
RA2: (*to HH*) put them at the other side then (.) Heather . so
PA35: I've been getting this prescription (.) for . for a while {RA2: aha} and I got a: . a tablet added on just (.) about two month ago {RA2: mhm} and when I was looking at it and there was only <u>three</u> items on it and there should've been <u>four</u>
RA2: well I need to get a <u>doct</u>or to do it. so what is the name of the tablet?`
PA35: pet . I can't remember (2) I'm no a good reader . I just taen them you know (.) I was looking for the box this morning (1) I noticed it was (one word unclear) but I'm no a very good reader . so it- I couldnae remember the name of them (*sniffs, sighs*) (4) so it's just the new one that's just been || two months . yeah
RA2: || I'll just check your record (.) hold on a minute (*phone starts ringing*) (6) <u>Tram</u>adol (3) <u>Tram</u>adol it's called
PA35: yeah . aye
RA2: no but if I say that (.) you can remember if anybody asks . it's <u>Tram</u>adol (2) there we ↑go . that be Wednesday . is that o<u>kay</u>?
PA35: yeah
RA2: in the afternoon
PA35: (2) is . is that it then?
RA2: that's it . if you just (.) put it (*questionnaire*) in the box . thank you
PA35: thanks very much
RA2: okay . do you want me to do it for you?
PA35: thanks

05-36 RA2: right . okay . no problem

05-40 *P returns for prescription after seeing doctor.*

06-12 **F/26-41/lw/ow**

RA2: hi: (7) that one (*consent form*) . and I'll swap one with you (*questionnaire*) . once you've (1) have you got an app<u>oint</u>ment?
PA36: no: em . it was to <u>make</u> an appointment with the <u>asthma</u> nurse
RA2: yes . certain<u>ly</u> . if you want to fill that up whilst you're waiting
PA36: aye
RA2: the asthma nurse . eh? she's on holiday . sh- . e:h . so it'll be after the New Yea:r
PA36: the first available appointment?
RA2: the first available . o<u>kay</u> (18) so it's Tuesday the seventh of January (.) in the ↑morning . ten thirty be okay? or d'you want it twelve thirty?
PA36: (.) twelve thirty
RA2: and the name is?
PA36: J R (*woman's name*) . it's for M R (*girl's name and surname*)
RA2: M (*repeats first name*)
PA36: I'm her mother
RA2: (2) the ↑add<u>ress</u>
PA36: thirty three (.) B Avenue
RA2: (2) thirty (*child is crying*) (8) okey dokey

07-29 PA36: (.) thanks

07-31 **M/26-40/ly/ey**

RA2: ↓morning
PA37: eh (.) I've got an appointment for <u>ten</u> <u>to</u>

RA2: you've got one?
PA37: yes
RA2: can I ask you to . sss quickly fill that in and put it in the box (*questionnaire*) (1) toda:y . Dr . the name please?
PA37: Mr M
RA2: it's room one . if you <u>have</u> a seat he'll call your name
07-47 PA37: okay

07-50 *Phone rings 3 times and continues to ring. RA2 asks caller to hold.*

08-05 *Phone. RA2 undertakes to pass on a message.*

08-37 RA2: (*talking to self*) I'll get that in a minute . right . twen- thir- first . what'm I doing? (.) I want a calendar

---

08-52 *GP gives signed prescription to RA2.*

08-57 *Phone. RA2 arranges appointment.*

09-18 RA2: twenty-thi:rd (15) must be in the afternoon then

09-44 *Patient asks for baby milk. Phone rings 5 times. RA2 asks caller to hold.*

09-49 *RA2 tells CR that somebody is waiting for baby milk.*

09-49 *Phone. RA2 arranges emergency appointment.*

10-11 *RA1 and RA2 continue discussion of Christmas trees.*

10-37 *GP gives another signed prescription to RA2*

10-38 *RA1 and RA2 continue discussion of Christmas trees.*

11-08 *Phone rings 3 times. RA1 arranges telephone surgery appointment.*

11-44 *RA2 deals with several problems: somebody has been smoking in waiting room. RA3 is having difficulty in opening computer program and practice secretary has a query about a prescription.*

14-19 *RA2 tells RA3 how to log on to the computer.*

14-43 *Phone rings 12 times. RA3 asks caller to hold.*

14-51 **F/16-25/lm/esm**
RA3: yes::?
PA38: could I make an appointment please
RA3: just give me one moment
HH: (11) (*very low voice*) if- if they hand you a form can you hand out a questionnaire
RA3: yeah (4) is it the first available appointment?
PA38: yeah
RA3: (10) the first one I have at the moment's:: ( ) Friday the twentieth at three twenty with Dr Carrington

PA38: that's fine (*sniffs*)
RA3: (.) and what's the <u>name</u>?
PA38: it's D W (*woman's name*) (.) (*sniffs*)
RA3: (3) and the add<u>ress</u>?
PA38: 9 M Terrace (*phone rings 2½ times*) (4) (*sniffs*)
RA3: (*whispers*) there you go
15-55 PA38: (several words unclear)

16-09 NCP

16-12 *RA3 apologises both to a caller and to a non-consenting patient at desk for keeping them waiting.*

16-40 *Phone rings 10 times. RA3 asks caller to hold.*

16-44 *Phone. RA3 arranges appointment with telephone surgery. Phone starts ringing again as she is doing this.*

18-33 **M. No details.**
PA39: I'm just waiting to hand it in (*prescription order*) . I'll put a ticket on
CR: (2) I'll get it . can you manage?
PA39: aye . think so
CR: (2) there you go=
PA39: =there's only one on it (?honey)
CR: that be Wednesday after two || okay?
PA39: || aye . want this?
18-49 CR: thank <u>you</u>

18-49 : *Phone. RA3 apologises for delay and explains to caller that person she wants will be back later.*

19-30 NCP

19-59 NCP

20-25 **F/41-60/lm/esm**
PA40: (*overlaps with NCP*) can I just gie you it so I can go? (*consent form*)
RA3: wh- . ye- . have you had:?
PA40: (.) what?
RA3: this- this is . what <u>this</u> is about . there's a questionnaire to=
PA40: =oh . I've got <u>that</u> to fill in as well?
20-39 RA3: it's- well it's just a (.) tick-off questionnaire . then if you could put it in-

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22-01 *Phone rings 3 times.*

22-27 *Phone rings 2½ times.*

22-42 *Prescription hand in.*

22-48 RA3: (*calls to waiting area*) prescription for Mr M (*to NCP*) I was lucky one o the
22-56 doctors walked through there as I was getting that (*to HH*)

23-32 *Prescription hand in.*

24-14 *RA3, CR, IA and HH speculate that the surgery is quiet because Christmas is approaching.*

R3 does paperwork at desk.

25-49 CR: ah well . I'm going for my tea . that lady's no turned up

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26-28 *Phone rings 2¼ times.*

26-57 *ARA1 comments to IA about the weather and the postman.*

27-11 *Phone rings once.*

28-00 *NCP waits at desk for RA3 to return.*

28-22 NCP

29-16 *Prescription hand-in*

29-44 *Prescription hand-in.*

29-56 *HH and RA2 discuss why patients handing in prescription repeats don't give consent.*

30-28 **F/75+/lw/om**

PA41: have I got another one there? (*consent form*)
RA3: that's (.) just a wee tick-off . form . for you (*questionnaire*)
PA41: (1) I've got an appointment for Dr Brown at h- (.) half past eleven
RA3: (1) what's the name?
PA41: M I (*woman's name*)
RA3: okay Mrs I . if you take a seat {PA41: right} Dr Brown'll give you a call shortly ‖ it's room seven
PA41: ‖ right . thank you (3) see if my brains'll work . hm hm (*on*
30-51 *questionnaire*)

30-57 *HH makes comment to RA3 about non-consenting patient.*

31-10 **F/41-60/lm/esm**

RA3: thank you
PA42: e:r . they two go thegether (*prescription orders*) (*phone rings, 3 times*) (1) this one actually does . it runs out on the twenty sixth . I don't know if he'll gie me it or no . if he'll gie me it earlier or no
RA3: (.) he will do (.) because we're- we're . it's {PA42: aye} we're on holiday that day {PA42: right} so that shouldnae be a problem if you
PA42: (.) ‖ he'll probably
RA3: (.) ‖ that's the second . this is the second part of this . if you just want to tick off (.) how you feel about it and then (.) put it ‖ in the box for me
PA42: ‖ I'll put it in there . right (57) (*P42 fills in questionnaire*) will I get that Wednesday?
32-34 RA3: Wednesday after two

32-37 *RA3 and HH discuss questionnaire.*

33-20 *Phone rings 3 times. NCP at desk.*

33-36 *Phone rings twice*.

33-49 *Phone rings once. RA3 arranges 2 appointments.*
35-40

35-41 **M/61-75/lm/esm**

RA3: yes . sorry about that
PA43: the questionnaire thing (.) hm (5) (*papers exchanged*) yes (.) aye we (.) fill them up the now and put em in here do we?
RA3: yeah
PA43: aye . right . er . I'm in for two . eh (*sucks in breath*) e::hm (.) prescriptions . one for the wife and one for myself. M R (*man's name*) and M R (*woman's name*)
RA3: (10) when were they put in Mr R? (*says name wrong*)
PA43: er . last . Wednesday (*clears throat*) shouldae been collected Friday
RA3: (17) what's your first name ‖ Mr R?
PA43: ‖ M
RA3: (.) pardon
PA43: M
RA3: (4) I'm maybe mishearing . what was the f- surname again . sorry
PA43: (.) R (*gives name again*) . - - - - (*spells out name*) - - - - (*spells out name again*)
RA3: (17) <u>there</u> we go
PA43: (*sniffs*) (3) thank you
RA3: that's you
37-14 PA43: ta (2) I'll fill this up then eh . ha (*phone rings*)

37-15 **M/25-41. n.a.**

RA3: ‖ yes:
PA44: ‖ morning (.) I don't know how to explain this . I've just been to the chemist (.) and I was picking up my Dad's: (.) repeat prescription {RA3: aha} and not all the stuff: (.) has been put on it (.) and I'm just wondering (.) why: hh (1) they say in case it was coming down in two parts which I found quite
RA3: right . what's the name?
PA44: it was JK (*man's name*)
RA3: (3) and the add<u>re:ss</u>?
PA44: 249 N Drive (*phone starts ringing*)
RA3: (29) right . there's th- three items went through . sh-. how- how many . how many should it've been? (1) do you reckon there's
PA44: e:r . there shouldae been the (.) suspension as well which I was . I put down for <u>two</u> bottles of that and (.) I don't know if that's on the computer as <u>two</u> . or <u>one</u> (.) and I don't know if I put down for the granules . the granules aren't a great necessity but it's the suspension that I'm almost run out of (.) (*sniffs*)
RA3: (.) right could you leave that until after four this afternoon ‖ and I'll get a doctor to get that
PA44: ‖ n::: no really cos (.) I live in Edin- . er through in Livingston and I've got to travel back and forf (sic) (.) ‖ and my <u>Dad</u>'s staying with <u>me</u>

RA3: || unfortunately it's items that I've got to get a doctor to do {PA44: o:::h} and I can't . and I- I need to get them to actually {PA44: ts:::} physically do the prescription || and sign it

PA44: || do you know (.) why they weren't done then?

RA3: I . I have no idea . I'd need to go . what . find out what day you handed it in and go and {PA44: yeah} check on the request slip {PA44: yeah} to make sure that they've definitely been requested

PA44: ri::ght cos they're all . ticked off (1) that's the stuff I really need . it's just more inconvenient cos my Dad's staying with me while my Mum's in hospital like . you know

RA3: aha . if you just give me || a se-

PA44: || right . okay . no problem

39-03 *Phone has rung 28 times. RA3 asks caller to hold.*

39-07 RA3: (*inbreath*) a::h . what . do you know what day it was handed . the request was handed in?

PA44: (2) l:ast (1) pw:::: Wednesday or Thursday I think

RA3: Wednesday or Thursday

39-19 PA44: I think (.) kyu

39-20 HH: shall I . I'll take || that off you (*consent form*)

PA44: || oh . okay . ta

HH: that's the the bit of that (*questionnaire*)

PA44: || alright . is it-

HH: || while you . while you're waiting

PA44: right that's fine (2) e:r does it matter if pen or pencil?

HH: er yeah . no . it doesn't matter

39-30 PA44: (*fills in form at desk muttering under breath e.g. "it's no my practice")*

39-58 *Phone rings 2½ times*

40-00 PA44: maybe sending you on a wild goose chase there (1) hhh

RA3: (1) it's just we've got to do this || or

PA44: || yeah . no . I understand (5) it's just that my (.) Mum's neighbour's phoned him up to say that the (.) chemist had delivered the stuff but obviously they can't get in cos there's no-one there {RA3: yeah} so I went this morning and I looked in the bag and it- . it's no all there . (she) looked at me and I'm (.) "what is it?" . she says "you'll have to go and check with the doctor" . I went "oh" . (*draws in and releases breath*) (7) no it was on one of the (.) prescription forms like that || (*sniffs*)

RA3: || it was on one of these ones || right?

PA44: || aye . I got that the last time . I- I just ticked them off and (1) what I needed (*sniffs*) (2) yeah . that's it (*sniffs*)

RA3: (3) that's probably why (.) for some reason there's two

PA44: aye . it's two different things though (3) that's || don't need that

RA3: || aha . that's the three . that's what mi- . || what I mean

PA44: || yeah (.) that's . no for that . and times two for tha:t

RA3: I see (*several garbled words*) they're no . eeh hee

PA44: they know what times two means like

RA3: well they know what times two means but (.) I mean you want something and you've crossed that as you don't want and you've crossed that as well || and the girls've actually

PA44: || I was needin <u>two</u> (.) that's why I put times two . that's what I use with <u>my</u> doctor . you know . didn't think it was too hard that one . I'm es no saying <u>you</u> . I'm just thinking the <u>doctor</u> . I'm no thinking it too hard to (.) understand that one

RA3: (.) well I- . it's bec<u>ause</u> there's a cross that it's {PA44: yeah} it . the other three items've {PA44: yeah} been ticked {PA44: yeah} and those two've been crossed and they've taken it that they didn't (PA44: yes} they didn't want . they couldna || looking at that you could actually take it as .

PA44: || yeah but (.)
what's the . what's the <u>two</u> for then? (*laughs*)

RA3: well (.) those . they two items (.) two items crossed off

PA44: yea:h . I can understand that as well like you know but (*sucks in breath*)
|| it's no that

RA3: || it's. it's easy done {PA44: mmm} (.) e:m (.) if you take a seat I'll see if I can't get a hold of a doctor to do that just now for you=

PA44: =if you wouldn't mind it would be <u>very</u> much appreciated

RA3: er . you might need to wait for a wee while . that's the only thing . okay?

41-51 PA44: (*moving away*) better than coming back . tha:nk you

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41-57 **F/41-60/ly/esm**

RA3: I'll be with you in || a second

PA45: || it's okay (1) my appointment's for half past eleven . J B (*woman's name*)

RA3: (7) that's Dr Mertoun . room one . if you take a seat || he'll give you a call when he's ready

PA45: || fine thank you (.)

42-13 o<u>kay</u>

42-14 *RA3 apologises for delay.*

42-22 *RA3 makes phone call, looking for doctor.*

42-31 NCP

42-36 *Phone. RA3 asks GP to write new prescription for PA44.*

43-12 *Phone rings. RA3 apologises for keeping caller on hold and puts through to another line.*

43-52 *Phone rings 13 times. RA3 arranges appointment.*

45-00 **F/16-25/lm/esm**

RA3: yes:

PA46: just er . handing in a prescription (1) if I can find it

RA3: (6) thank you

PA46: do you want me to hand that in and all? (*consent form*)

RA3: aha . if you could just tick off that for us (*questionnaire*) that be great thanks

45-16 (*phone rings 4 times*)

45-28 NCP

45-40 *Phone rings three times. RA3 advises caller to phone after 2 p.m. for test results.*

46-13 *Phone has rung 11 times. RA3 takes a message for a member of staff who is not at work.*

47-54 *RA3 asks DA3 to sign prescription for PA44.*

48-06 *Phone rings 22 times. RA3 asks caller to hold.*

48-10 **M/61-75/lm/om**

RA3: yes:

PA47: morning (.) I've er . a prescription to pick up for Mrs D . 28 R Street

48-29 RA3: (12) (*whispers*) there we go (.) there's your prescription

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48-31 NCP

49-09 *HH comments to RA3 that there's a lot going on.*

49-36 *HH tells RA3 about some papers she found on her chair after the tea break.*

50-08 RA3: I wonder how he's (.) managing with that prescription
Phone rings twice.

50-19 *RA3 asks ARA1 to check if prescription is ready.*

50-28 NCP

50-39 ARA1: Mr K (*P44*)

RA3: (2) Mr K (*calls into waiting area*) (4) there you↓go=

PA44: =thank you very much

RA3: you're welcome

PA44: cheers again then . cheero:

50-48 RA3: by:e

50-50 *HH and RA3 discuss prescription problems.*

51-24 *Phone rings 10 times. RA3 arranges for doctor to deal with a problem.*

53-09 **F/41-60/ly/o**

RA3: yes:

PA48: hi . I have an appointment for twenty to twelve (.) E N (*woman's name*)

RA3: (5) that's Dr MacLaverty room four . if you take a seat {PA48: that's fine} he'll give you a call when he's ready

PA48: right . thanks

RA3: there's (.) this wee questionnaire to ‖ just to tick off . it's

PA48: ‖ oh . do you take that

53-26 RA3: it won't (?be) a moment

54-29 *Phone rings 2¼ times*

54-46 *RA3 calls GP and asks him to get in touch with her.*

55-14 *GP arrives at desk and RA3 explains problem to him.*

56-22 *Phone rings*

56-24 NCP

56-35 *RA3 tells GP about house calls.*

57-08 **F/41-60/lw/esm**

PA49: hi . I've got an appointment (1) ten to twelve
RA3: what's the name?
PA49: SG (*woman's name*)
RA3: (5) it's Dr Mertoun room <u>one</u> {PA49: fine} if you take a seat he'll give
57-20 you a call when he's ready

57-21 *GP and RA3 continue to discuss house calls.*

57-48 *Phone rings thirteen times.RA3 arranges appointment.*

58-44 *Phone rings ten times. RA3 deals with query.*

59-51 **F/41-60/lm/ey**

PA50: hi there
RA3: hi:
PA50: (1) would- . do I- . there are two pieces to that (*prescription order*) . so do I (.) put (.) a sticker on each one? . or just one=
RA3: =no just on- on the (?third) one if the items are for the same person . and is it the items th- . you've crossed that you want? . or
PA50: ye:ah (.) the items that's (.) crossed
RA3: right . you're actually better giving them a tick as crossing them {PA49: oh right} because some people cross it meaning (.) they don't want it
PA50: (2) right . I'll tell him (.) he's to (.) put a tick at the ones (1) when you put in your prescription it's a cross you've to put on it you see (2) aye. in the chemist || like
RA3: || in the chemist . I see . oh r-
PA50: (1) so
RA3: (.) just up there's fine . thank you (1) that's lovely . thanks {PA49: that's it} and that's a wee thing for you just to (*questionnaire*)
PA50: (.) fill in?
60-32 RA3: fill in

60-33 *Phone has rung 19 times. RA3 gives caller nurse's number.*

60-52 NCP

61-12 **F/41-60/lm/ey**

PA51: (*very fast*) that one there . is (several words unclear) . it's no for me . I'm visiting it. but will I put in that? . it's actually my p- (.) husband's prescription I'm putting in
RA3: yeah . just fill that in || for yourself (*questionnaire*)
PA51: || fill all that in as

RA3: for yourself . yeah
PA51: right . as if I'm- (.) just for myself?
RA3: yeah
61-24 PA51: oof

61-28 *Phone rings 8 times. RA3 gives caller phone number.*

61-49 NCP

62-15 **M/26-40/lw/ey**
PA52: eh I've got an appointment at ten to
RA3: what's the name?
PA52: W (*surname*)
RA3: (2) it's Dr Brown room seven {
PA52: ‖ nae problem . right
RA3: ‖ if you take a seat she'll give you a call when she's ready (*tails off as P52*
62-26 *moves away*)

62-27 NCP

62-30 RA3: excuse me sir (*hands questionnaire to P52*) just a wee tick off

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62-34 NCP

62-49 *Phone rings 6 times. RA3 arranges appointment.*

63-34 **M/75+/lm/om**
PA53: what do I do with this? (*consent form*)
RA3: if you could just give me a moment sir cos I've got s:omebody else
‖ (?to speak to)
PA53: ‖ alright . sorry
RA3: if you could just give me a second
HH: it's just a
RA3: it's just a . it's just a wee tick-off slip
PA53: alright
RA3: the pen's there {PA53: right} the wee tick-off slip's there . okay?
63-46 PA53: thank you

63-51 *Phone rings 3 times. RA3 asks caller to hold.*

63-57 *Phone. RA3 asks caller to hold.*

64-04 *Phone. RA3 arranges appointment.*

65-12 **F/26-40/lm/esm**
PA54: appointment for twelve o'clock (*two words unclear*) (.) ‖ (one word unclear)
RA3: ‖ what's the name?
PA54: em P N (*woman's name*)
RA3: it's Dr MacLaverty . room fou:r . if you take a seat he'll give you a call when he's ready . and if you could just (.) do that wee tick off one for me thanks (*questionnaire*)
65-25 PA54: a:w . right

65-44 NCP

66-11 *Phone. RA3 explains to caller how phone system works.*

66-47 *RA3 laughs with HH about how she's managing work.*

66-57 *Phone rings twice.*

67-20 *Phone rings twice.*

67-50 *Phone rings twice. RA3 puts caller through to RA4.*

68-36 *RA3 comments to HH that she can "breathe again".*

68-55 NCP

69-04 **F/26-40/lw/om**

PA55: I'm a bit la:te (2) give you that (*consent form*) (1) e:h . I've got an appointment at ten to

RA3: (7) right . it's Dr MacLaverty room four . if you take a seat he'll give you a call when he's ready

PA55: is he . is he late or

RA3: (1) he's running a wee bit late . he's no that bad || though

69-25 PA55: || good

69-39 **F/41-60/sm/esm**

RA3: yes:

PA56: hi:=

RA3: =hi

PA56: em I don't think I (.) I'm- . I think I'm still on Dr MacLaverty's register cos we've been in- in- . abroad for six month (.) and I need some repeat prescription . do I just carry on as normal?

RA3: (.) er: || I'll (.) just double check (.) that you're still registered

PA56: || I'm sure (.)I'm still on the register

RA3: what's the name?

PA56: A S (*woman's name*) . there's A . T and V (*woman's, man's and ?girl's first names*)

RA3: (3) what's the address?

PA56: 7 B Side

RA3: (3) well . you're definitely still registered {PA56: yes} so I take it the whole family (.) || still is

PA56: || so (.) how do (.) I go about (.) doing the tablets on here (1) cos . never remember (*laughing voice*) cos I normally phone up

RA3: it might be worthwhile as - . as it's not- . as it's been sic- six months since you had it from here . just to write a wee note . reminding them . that you have been abroad (.) for six months

PA56: okay . I'll have to find out (.) even if I do it over the phone then (.) cos V'll (*girl's name*) probably need hers soon

RA3: (.) y- if- . even if you do it on the phone or when you're here . if you're gi- giving it to the girl that's taking the prescription off you or you're leaving it (*R4 answers phone, which has rung six times*) on the th- answering machine

. just mention {PA56: just mention it} that you've been away {PA56: yeah}
(1) for that length of time

PA56: yeah . okay

70-57 RA3: (12) this is a wee questionnaire that goes along with this:

70-38 *Phone. RA4 deals with query about sick line.*

72-38 NCP

Practice A, Disc 3, Track 2: 12-15 a.m., Monday 16th December 2002

00-14 NCP

00-28 **M/61-75/lm/ey**

PA57: (*handing in consent form*) there you go (.) thank you
HH: can you give out the: er (?them) the questionnaire?
RA4: (2) right (.) (*to P57*) apparently I've to give you that
PA57: (.) right
HH: and that goes on the pile (*consent form*)
RA4: right . okay?
HH: (.) || thanks . hu hu hu
RA4: (.) || hh
PA57: I've got an appointment with the nurs:e (.) twenty past twelve hen
RA4: (4) what was the ↑name?
PA57: eh . L (*surname*)
RA4: (3) right . if you just have a seat B'll (*nurse*) come out and give you a call || okay?

00-55 PA57: || right y'are then

00-56 *HH explains to RA4 what to do with consent forms.*

01-15 PA57: does this go on- in here aye? (*questionnaire in box*)
RA4: (1) yep . that's great . tha:nks
PA57: (.) I've just pinched your pen . that's how I get pens || see
RA4: || (*loud*) ha ha he he he
PA57: ha ha

01-27 RA4: thank you

01-36 *RA4 tells other receptionists about flowers she has bought for RA6 whose mother-in-law has recently died.*

01-49 **M/61-75/lw/esm**

RA4: hello!
PA58: hello . can I see the (.) Dr MacIntyre on the (.) seventh
RA4: on the seventh of || January
PA58: || January
RA4: right . cos you've filled out one of those (*consent form*) there's that (*questionnaire*) . okay? (.) now we'll see what we can do || I don't know whether I've got that
PA58: || (*to IA1, jokily*) see what you've started
RA4: see (?what) you've started
HH: ha ha
IA: I'll give you . I'll help you with it if you like
PA58: you havenae . you'll only bloody do it for me {HH: hh hh} where's my specs?
RA4: now you're looking at Tuesday the seventh (.) I don't have the appointments that far ahead yet
PA58: so when do I come back?
RA4: e::rm (.) the end of this week . I've got the week pre:vious
PA58: well don't be putting onybody in front of me
RA4: (.) what about Friday the thir:d?=

PA58: =no: Tuesday
RA4: no? . right . well you need to come back towards the end of this week {PA58: aye} okay? (19) (*clears throat and coughs*) if you fold it up and just put it in the:re
PA58: (5) (*to IA1, teasing*) I'm gonna miss my bus (.) can you (?hold) that bus for me T (*man's first name*)
RA4: (4) thank you: (2) hh hh || can you not fit it in?
HH: || the hole's . the hole's too small (*in box for questionnaires*)
RA4: (4) got it?=
PA58: =right pal || that's it
03-13 RA4: || thank you:

03-23 *HH and RA4 discuss maintaining confidentiality of questionnaires.*

03-40 NCP

04-02 *RA2 and RA4 discuss how they will deal with prescriptions since one of the computer's is not working.*

04-23 **M/61-75/lw/every two weeks**
RA4: hi there
PA59: hello . is there any way- . chance (.) of me seeing Dr Mertoun this week?
RA4: e:r . unbelievably I don't think so . I'll tell you why: . in a moment (2) he actually goes on holiday for four weeks (.) on Wednesday (1) e:rm (2) what about f- . three o'clock on Tuesday afternoon (2) I'm squeezing you in
PA59: (.) Tuesday
RA4: that's ju- . yeah . his last day before he goes off for four weeks
PA59: what date (.) would that be?
RA4: that's the seventeenth of December
PA59: seventeenth? . fine . thank you
RA4: what's the na:me?
PA59: OJ (*man's name*)
RA4: (14) (*quietly*) just write that appointment time down for you (3) that's tomorrow at three o'clock
PA59: || thank you
RA4: || right . okay . I've now got to give you one of these (*consent form*) (.) and ask you to fill that (*questionnaire*) in if you wouldn't mind
PA59: and can I bring it back tomorrow rather than . do it just now? . or would you like me to do it just now? (.) right . can I borrow your pen?
RA4: yes . on you go . yeah
PA59: thank you
05-43 RA4: (2) (can you) manage?

05-44 NCP

05-59 *Phone rings 4 times.*

06-10 *HH tells RA4 not to bother with questionnaires if it's too much trouble.*

06-30 *Phone rings once. RA4 arranges for doctor to call patient. Phone rings 20 times during call.*

06-37 PA59: that was easy . pop it in here? (*questionnaire in box*) (.) thank you
06-45 HH: (.) it's alright . I can er . I can take that for you if you like

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08-43 *NCP*

08-48 *Physiotherapist appointment*

09-12 *NCP*

09-39 *RA4 tells HH that she doesn't feel very organised then sighs and coughs.*

10-14 *NCP*

10-26 *NCP*

10-46 *RA4 makes call but doesn't reach person she wants to speak to.*

11-00 **F/21-40/lm/om**
PA60: hi . I've to pick up a: . prescription
RA4: (.) I've to give you one of these now apparently
PA60: right
RA4: okay . and what's the name of the prescription?
PA60: it's BR (*woman's name*)
RA4: (3) can I take the address please
PA60: 25 R Court
RA4: there you go . that's the scrip for you
PA60: that's lovely || thanks
11-18 RA4: || okay thank <u>you</u>

11-45 RA4: (*PA60 puts questionnaire in box*) thank you=
11-46 PA60: =right . thanks

11-51 *HH asks RA4 to sign a consent form.*

12-09 *RA2 checks details of "clinics for bloods", which are organised by RA4.*

Practice A, Disc 3, Track 3: 2-45 p.m., Monday 16th December 2002

00-37 *HH and RA5 greet each other*

00-39 *Phone rings 13 times. Caller wishes to get test results but, after checking with RA2, RA5 explains that they are not yet available.*

03-42 *HH explains to RA5 what she and IA1 are doing.*

04-54 *HH asks RA5 to sign consent form.*

05-28 *Phone rings twice. RA5 agrees to arrange something for caller. Phone rings again, twice, during call.*

06-09 *Phone rings twice and continues to ring after being answered. reception.*
6-57 *RA5 asks caller to hold.*

07-00 *Phone rings 9 times. RA5 asks caller to hold.*

07-11 *Phone rings 4 times. RA5 asks caller to hold.*

07-21 *Phone rings 4 times and continues to ring after being answered. RA5 cancels appointment for caller.*

07-57 *HH remarks to RA5 that there's a patient approaching the desk.*

08-30 *RA2 tells RA5 about patient's test results.*

08-41 *Somebody, possibly midwife, leaves something at desk. Comments on how busy it is.*

08-53 *Phone. RA5 gives test results to caller.*

09-40 *Phone. RA5 tells caller that test results haven't arrived.*

10-51 **F/41-60/not her practice**

RA5: sorry I've kept you waiting
PA61: (.) I'll give you this first (*consent form*)
RA5: (2) I'll (?take) that and I can give you that (*questionnaire*)
PA61: (.) oh god . || have I to fill this in before I ask questions?
RA5: || ha ha ha
11-08 I think so . hm hm hm hm hh

PA61 fills in questionnaire , talking to herself: 'e::rm…e:rm… e:m …ha ha ha . I like this one'..

11-37 **F/26-40/lm/esm**

PA62: hiya . I've got an appointment for half <u>past</u> . eh MM (.) LM (*women's names*)
RA5: (10) sorry . what was the name again?
PA62: MM . M . it'll either be M or L
RA5: it's M that's here

PA62: right
RA5: it's with Dr MacLaverty {PA62: right} it's in room four . if you just take || a
PA62: || can I gie you that? (*consent form*)
RA5: oh right . didnae realise you had one as we:ll
PA62: it's room?
RA5: || four
12-12 PA62: || four? . right . hh hh . right . thank you

12-20 PA61: em: (.) I'm here on behalf of my mother . MS . who is moving into sheltered accommodation . just down the road . at the A
RA5: (.) Gardens
PA61: Gardens . so: . we need to change our: (.) doctor . because she's from U (.) e:m do we get a form or something for her?
RA5: new patient form
12-37 PA61: right . okay

13-24 RA5: (*returning from back*) right that's {PA61: right} that's a wee leaflet about the practice
PA61: about the place eh? . cos I don't know anything about it {RA5: right} is it sort of like the one practice like? . we're from U (*name of town*) and we have different sort of practices under the one roof . so . is it just || the one?
RA5: || no it's just the one
PA61: it's just the one (.) that's fine
RA5: aye it's just the one here {PA61: that's fine}. and that's . that patient form . and that's just a wee questionnaire to be filled in || as <u>well</u>
`PA61: || okay
RA5: and if you fill them in and get them . eh . is she able to come to the surgery at all?
PA61: e::r
RA5: cos what normally happens is . eh . new patients get a: patient exam {PA61: yes} from the nurse
PA61: yes . yes . yes . I can:
RA5: (1) aha . I think somet-=
PA61: =they go down to the centre=
RA5: =they get a home visit if they're no able to come up=
PA61: =she's a bit frail . e:m . I mean I could . I could technically sort of bring her during . it would be . have to be over . during the Christmas period . when I'm off . other than that (.) em (.) she's she's down at the centre after that {RA5: right} you know . em (*phone rings 4 times*)
RA5: (1) I don't know if I-
PA61: so I'm- (3) do you have an-?
RA5: e:h . see what I've . got (5) don't know if there's any . so you're talking about between Christmas and New Year then is it?
PA61: probably (.) something like that (1) or if anybody was available for that . no?
RA5: (*phone starts ringing*) (6) no got <u>any</u>thing for then
PA61: right (.) em (1) as I say if- if . I mean . if they go down- . if they do home visiting . I mean she isn't- . she can't . she can't come on her <u>own</u> . you know . somebody would have to come with her
RA5: aha
PA61: em
RA5: if she's no fit we would send somebody in

PA61: aye yes . yes down to vis- . down to the centre . right . okay
RA5: somebody would call in . okay?
15-27 PA61: thanks very much

15-28 *RA6 suggests that RE5 answer the phone while she logs on to the computer.*

15-38 *Phone rings 14 times. RA5 suggests that caller phone the next day at 3-30 for appointment.*

17-03 *RA6 and RA5 change over. RA6 asks RA5 if she's dealt with midwifery problem.*

17-36 *Phone rings twice. RA6 arranges for doctor to call patient*

18-49 *RA5 tells RA6 about papers which doctor has brought out for filing.*

18-54 **F/41-60/there for others/om**

RA6: can I help you?
PA63: aye . you're gonna love me (.) A Gardens
RA6: aha (.) that's them all?
PA63: that's them all
RA5: and you know they'll no be ready until Thursday (.) afternoon after two o'clock
PA63: right . because there's only two of them that's urgent . em and that's the top two but (.) as-soon-as would be great anyway
RA6: the- . there are . they two are urgent=
PA63: =they two are urgent . aye=
RA6: =really needed (.) right
PA63: they've got no: . (?Aspirin) . at all
RA6: right (.) right . leave it with us but the rest'll be Thursday after- after two . okay? (.) right that's fine (.) that's you . okay?
PA63: right . will I just fill it in and hand it back?
19-31 RA6: aye . well you put it in the box . okay?

19-32 *Phone rings 6 times and continues to ring after being answered.RA6 puts caller through to doctor.*

20-25 *Phone rings 2½ times.*

20-33 *NCP*

20-56 *Phone rings twice. RA6 answers query about prescription.*

22-35 *Phone rings 2½ times.*

22-53 *Phone starts ringing again.*

23-19 RA6: *Phone rings 10 times and continues to ring after being answered.. RA6 undertakes to put patient query to doctor.*

26-06 **F/61-75/lm/om**

RA6: ye:s . hello:
PA64: there's a form first . is that what I've to give you? (*consent form*)

RA6: that's it and then I give you one of them (*questionnaire*) {PA64: right} there you go
PA64: ta
RA6: okay?
PA64: mhm (.) now . I'm putting in a prescription {RA6: aha} and I need . I need the ones that's over-leaf . for Thursday . I don't need that one till Friday again (*phone starts ringing*)
RA6: well they'll all be ready for you {PA64: aye} they'll all be ready for you ‖ for Thursday anyway
PA64: ‖aye . I thought that . that would save . two . lines going in=
RA6: =aye . nae bother
PA64: now . is there any chance of an appointment for Dr ↑Mc in: . January?
RA6: in January? . wait a wee sec (4) Dr MacIntyre: . January . (*louder*) third o' January . is that any good to you?
PA64: e::h
RA6: nine o' ↑clock? (*phone starts ringing*)
PA64: na . e:h . what day's that?
RA6: it's a Friday
PA64: it's a Fri- . aye that'll do
RA6: nine o' ↑clock?
PA64: okay
RA6: and what was your ↑name?
PA64: K . C
RA6: (.) K with a C? (*spelling of name*)
PA64: no . K ‖ with a K:
RA6: ‖ with a K
PA64: mhm
RA6: (3) and your date of birth?
PA64: nineteenth of the nine . thirty-four
RA6: right . that's you . Friday the third (.) ‖ of January
PA64: ‖ at ‖at nine
RA6: ‖ are you wan(t)in' a wee card?
PA64: aye . gie me a wee ca:rd
RA6: (5) that's at nine o'clock (.) with Dr MacIntyre (2) ‖ okay
PA64: ‖ that's lovely . ‖ okay . right . tha:nks . bye
27-23 RA6: ‖ that's you . okay then . ba-bye

27-24 RA6: *Phone rings 13 times. RA6 suggests that caller phone for an appointment at 3-30 on the day before it's required.*

27-47 **M. No details.**
PA65: can I collect a prescription for Mr AF please
ARA2: (19) yes
28-12 PA65: (5) thanks

28-01 *NCP*

29-20 *Phone rings 2½ times.*

29-32 *RA6 sighs and talks to HH.*

30-05 *RA6 agrees to sort something out for practice secretary.*

30-16 **F/41-60/lm/om**

(*phone rings 1¼ times)*

RA6: hiya

PA66: hi

RA6: (5) right . that's fine (*takes consent form*). and I'll gie you a wee questionnaire . there you go

PA66: right=

RA6: just pop it in the box

PA66: in the a- . a- . if I'd glasses . I just thought . I need . I've got an appointment at (.) quarter to

RA6: you've got

PA66: with Dr (.) MacLaverty

RA6: || Dr MacLaverty?

PA66: || it's Mrs D (1) HD

RA6: H . D . that's you . if you have a wee seat he's in room four

PA66: || right

30-45 RA6: || he'll give you a call

30-46 *Phone rings twice. RA6 tells caller that a prescription is ready to be collected.*

32-39 *Phone rings 2½ times.*

32-21 *RA6 whispers under breath 'right . Dr MacIntyre (5) was that toda:y? . mhm'. Phone rings 2½ times) RA6 explains to doctor that a patient ha shad a problem and was expecting a house call.*

33-44 P*hone rings 14¼ times. RA6 puts caller through to doctor.*

34-33 *Phone rings once. RA6 writes message to tell doctor that caller requires 'private line'.*

37-52 RA6: right (2) (*sighs*)

38-04 **F/26-40/ly/o**

RA6: hi there (.) thank you (3) thank you (*takes consent form*)

PA67: what

RA6: and if you just fill that in and put it in the box (*questionnaire*) (.) that's fine

PA67: (2) could I: . make an appointment as we:ll

RA6: mhm (.) when for?

PA67: as soon as possible (*sniffs*)

RA6: (4) what you would need to do for an appointment say for tomorrow . if you phoned us at three thirty today for ↑tomorrow . it's

PA67: (*sighs*) right

RA6: if you were really really needing one I've got one at twenty past four today . it's a cancellation (.) || if you really need an appointment

PA67: …….|| twenty past four?

RA6: aha

PA67: that's fine

RA6: that alright?

PA67: a:ye

RA6: and what was your ↑name?
PA67: eh AS (*woman's name*)
RA6: (.) other than that you're gonna have to phone every day (.) at three thirty {PA67: right} for an appointment for the next day {PA67: right} and your date of birth?
PA67: fourteen five sixty eight
RA6: that's you . that's today then . at four twenty
PA67: four twenty . oka:y (10) (*sighs and sniffs*)
RA6: (6) that's fine thanks
PA67: it'll no fit ha ha that's it . (1) right . tha:nks
39-18 RA6: okay then

38-25 *RA6 tells HH that her face looks familiar.*

40-46 *Phone rings 2¼ times.*

40-57 **M//61-75/lm/esm**
RA6: hiya (.) there you go . now I'll give you one of them (*takes consent form and hands out questionnaire*) (.) and if you fill that in
and pop it in that box (.) that's you
PA68: right . e::h (1) prescription
RA6: (.) and what was your name?
PA68: eh JH (*man's name*)
RA6: Mr H
PA68: right . just wanting me to tick off all this hen?
RA6: that's it . aye . your addre:ss Mr H (.) ‖ 55 B D?
PA68: ‖ oh for there . aye . 55 B D . aye right y'are
41-26 RA6: that's you

41-27 *Phone rings once.RA6 answers patient query. Phone rings 2¼ times.*

42-07 *Phone rings twice. RA6 arranges for doctor to call patient.*

43-19 *Phone rings 4 times. RA6 arranges ambulance to take patient to hospital appointment.*

45-10 **F. No details.**
ARA2: you just handing one in?
PA69: I've got two to get out
ARA2: what's the name?
PA69: eh . JC and AD (*women's names*) (1) e:r
ARA2: (10) what's the address for JC
PA69: eh . one O four B Street . both of (?our) addresses
ARA2: and what was the other name?
PA69: AD
ARA2: (11) ‖ okay?
PA69: ‖ right . thank you . and that's that=
ARA2: =and are you wanting to put these ones in?
PA69: yeah . please
45-54 ARA2: (4) okay then . by:e

45-33 *Phone rings 30 times RA6 gives patient test result.*

46-14 *RA6 say sto ARA2that she needs to find ambulance book and notices that Dr MacIntyre has left papers on desk.*

46-45 *RA6 and ARA2 have whispered conversation about patient who phoned in for a sick line.*

47-37 **F/26-40/lm/om**

RA6: hiya hen (.) that's fine {PA70: h) and I'll gie you one of the:se and if you fill that in and put it in that box {PA70: oh} that be fine . there you go

IA1: (7) have you got a pen?

47-57 PA70: (.) a:ye . pen here

48-38 RA6: (*whispers*) right . B . M (*woman's name*)

48-56 **F/26-40/lm/om**

PA70: em . can I get a prescription?

RA6: (.) for yourself || A (*woman's first name*)?

PA70: ||a:ye (.) for myself

RA6: (2) your address was?

PA70: 26 M C

RA6: that's you

PA70: right . thanks

49-07 IA: (.) thanks for your help

49-32 RA6: right . so he's to be seen

50-01 *RA2 comments to RA6, HH and IA that it's very quiet in surgery, perhaps because of cold weather.*
RA6 asks RA2 if prescriptions for a particular nursing home should be kept together.

51-36 RA6: Mrs C . Dr MacIntyre:

51-55 **F/41-60/lw/om**

RA6: hiya

PA71: could I (.) hand these in please (*prescriptions*)

RA6: aye

PA71: och I forgot to put a number on them

RA6: oh aye . you'd better put the number on eh

PA71: och it's (?cold out) (*sighs*)

52-06 RA6: (3) (two words unclear)

52-15 *RA6 asks RA5 if she has the ambulance book.*

52-29 RA6: that's fine

PA71: I keep dropping things with the arthritis in that haund {RA6: aye} it's a bit clumsy right enough

RA6: you're alright

PA71: I just got to hand that in then (*prescription request*)

RA6: put that back in the

PA71: it come out of my hand there

RA6: aye you're alright

PA71: when I tried to tear it off {RA6: there} the things I've dropped in the house and (several words unclear)
RA6: stick on that {?R7: sorry M (*R6*)} it's alright . that's fine . r:ight that's (two words unclear)
PA61: I know how you feel
RA6: there we go
PA61: it's terrible that
PA71: oh I ken
PA61: I keep dropping my glasses
PA71: a:ye . it's (two words unclear)
RA6: are you gonna hand this in to me (*consent form*) {PA71: aye} and I'll gie you one of these? (*questionnaire*) . there you go ‖ okay?
PA71: ‖ right . thanks . can I take away a pen?
53-04 RA6: aye . oh aye

53-05 **F/41-60/lm/om**
RA6: yes . hello
PA66: I've just to (.) re- . remind him he's to phone me
RA6: remind . who am I meant to be reminding? . Dr?
PA66: MacLaverty . yes sorry (.) I'm just expecting you to know! . er that . on Monday . he's gonna phone me about eleven o'clock
RA6: right . so what did he say to you . for . you've to say to me to remind him?
PA66: yeah . just to remind him
RA6: about eleven o'clo:ck . put a wee message in the:re
PA66: so's that he disnae forget . which is
RA6: remember . is he gonna call ye?
PA66: he's got to phone me . aye . to
RA6: remember to phone . and your name is?
PA66: H D
RA6: H D
PA66: (2) it's for the sake of getting the res- . the result from St J's {RA6: right} he might get a (.) message
RA6: right . (?go on) . gie me your number as we- . so that . so that he doesnae need to look for it
PA66: ***** {RA6: aha} *** (.) *** (*telephone number*)
RA6: *** (*repeats last 3 digits*) and it was re results from St J's (2) right . I've put that in . and that's Monday . the twenty-third . and he'll . I'll put a wee note in ‖ for him
PA66: ‖ Monday the twenty-third?
RA6: aye . Monday's the twenty-third
PA66: is it? . my wedding anniversary
54-16 RA6: is it? . there you go . okay then . ba-bye . thank you

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54-18 *Phone rings twice. RA6 advises caller to phone again at 3-30 for appointment the following day.*

54-49 **F/26-40/lm/om**
PA72: do y'ave a (.) prescription?
RA6: and the name?
PA72: FM (*woman's name*)
RA6: FM

ARA2: M?
RA6: (4) and what was your addre:ss?
PA72: 24 R Drive
RA6: that's you
55-02 PA72: thanks very much

55-08 **M/75+/ly/om**
PA73: in here?
RA6: no yo- . you . you just pass me that {PA73: mm} and then I'll hand you a (.) a form
PA73: o:h right
RA6: if you fill that in and then put it in the box sir {PA73: right dear} that's fine . thank you
PA73: (.) I'm looking for an appointment . with Dr Mertoun . DW (*man's name*)
RA6: an appoint- . you're looking for an appointment ‖ with Dr Mertoun
PA73: ‖ aye (.) please
RA6: just a wee sec . now the first one I'd be able to give you for him . wait a wee sec . Dr Mertoun (19) now at the minute there isnae anything for Dr Mertoun . hold on tae I check . he's maybe going on holiday . wait a wee sec (12) he's actually going on holiday {PA73: ↓oh} for four weeks sir
PA73: just give me anybody please
RA6: right . no:w . right we'll see when the first available appointment is for you . wait a wee sec . I think it's gonna be next week {PA73: (*whisper*) o:ch:} e:m . unless you wanted to gie me a wee call at three thirty toda:y (.) and I would try and gie you one for tomorrow
PA73: right
RA6: now it is very busy {PA73: aye} e:h . if you didnae get . one when you called . or you didnae get through . if you call again at eight thirty tomorrow morning there's appointments released the:n . oka:y?
PA73: thank you
RA6: at three thirty today for tomorrow sir
56-37 PA73: (*moving away*) right . thanks very much

56-39 **F/75+/ly/om**
RA6: if you just fill that in and pop it in the box {PA74: mhm} that be fine
PA74: e:r . can I get . the repeat prescription for KS (*woman's name*) please
RA6: KS
PA74: aha
RA6: (8) one eighty six R Road?=
PA74: =that's it . aye
RA6: that's you
57-00 PA74: right thanks

57-01 **F/41-60/ly/es**
RA6: hello ‖ there
PA75: ‖ hi (.) got an appointment for Dr MacIntyre
RA6: right (.) if you can just fill that in and pop it in the box (*questionnaire*) {PA75: right} that be fine (.) right . and your name was?
PA75: SB (*woman's name*)
RA6: SB (3) that's fine (.) if you have a wee seat . a:nd he'll be in room two .
57-19 he'll give you a call . okay?

57-28 *GP tells RA6 that he's going out to visit a patient.*

57-57	*NCP*
58-08	*RA2 suggests to HH and IA that they take a coffee break.*

Practice A, Disc 3,Track 4: 3-35 p.m., Monday 16th December 2002

00-05	*Phone. RA6 arranges appointment for following day..*
00-33	*Phone rings 4 times.*
00-42	*RA6 clears throat.*
01-02	*Phone rings twice . RA6 arranges appointment for following day.*
01-41	*Phone rings 13 times. RA6 arranges appointment for following day.*
02-50	*Phone rings 12½ times.* RA6 *arranges appointment for following day.*

Practice A, Disc 4: 3-40 p.m., Monday 16th December 2002

00-16 *Phone rings 6 times. RA6 arranges appointment for following day.*

01-06 *Phone rings 3 times RA6 arranges appointment for following day.*

01-47 **F/41-60/lw/esm**

PA76: filled that (*consent form*)
RA6: that's fine . thank you
PA76: (*clears throat*) I've got an || appointment
RA6: || and if you just fill that in (*questionnaire*) {PA76: okay} and pop it in the box . and you've got an appointment for when?
PA76: yes . eh . for ten to four . HB (*woman's name*)
RA6: HB- (6) (*whispers under breath*) HB (6) that's you . it's Dr MacLaverty room four . he'll give you a call {PA76: right} okay?

02-17 PA76: thank you

02-28 *NCP*

03-24 *RA6 tells somebody who is looking for RA2 that she'll be back in a minute , or five minutes.*

03-33 **F/26-40/ly/ey**

PA77: hi || it's- . the lady asked me to hand that in (*consent form*)
RA6: || hello
RA6: that's fine . now if you just fill that wee one in there (*questionnaire*). and thenpop it in the box || thank you
PA77: || okay . em . I was just wondering . em . I used to live here . but I'm just visiting . and I was wondering if I can have a visitor's . em . appointment
RA6: (.) a visitor's appoi::nt ment? (.) how long are you staying here?
PA77: em . for six weeks
RA6: you're staying here for six weeks ( ) and when are you looking for an appointment?
PA77: maybe next week some time
RA6: (.) next week y- . I'll get you a form . okay? (10) if you f- . if you fill that in for me . make sure that you put your e:h . the address you're staying at at the moment . the address that you came from {PA77: mhm} your date of birth a:nd . the name and address of your doctor at home {PA77: okay} pass it back in to me and then I'll give you an appointment {PA77: okay then} for

04-23 next week. okay?

04-28 *NCP*

05-09 **F/26-40/lw/esm**

RA6: yes
PA78: hi . e:m I've got a repeat prescription to pick ↑up
RA6: (.) okay . if you just complete tha:t (*questionnaire*) and pop it in the box {PA78: right} . and what was the name || for the prescription?
PA78: || MM (*woman's name*)
RA6: MM (*phone rings 1½ times*) (5) what was the addre:ss?
PA78: 14 H Park

RA6: (.) that's you
05-27 PA78: right . thank you:

05-40 *Phone rings once. RA6 gives caller information about rearranged appointment.*

07-33 **F/26-40/ly/ey**
PA77: hi
RA6: right (15) (*phone rings 2½ times*) right . now the first one I'd be able to give you would be next Monday . is that oka:y?
PA77: okay (.) can you write it down for me plea:se?
RA6: I will write it down . aha (2) Monday . is it Monday or is it . perhaps . oh it's actually Tuesday {PA77: okay} Tuesday . Tuesday morning (1) Tuesday
08-09 morning . ten fifty . is that okay?

08-10 *Phone rings twice. RA6 asks caller to hold.*

08-28 **F. No details.**
ARA2: is there anybody waiting on a prescription?
PA77: no but have you got a pen? . please
ARA2: (2) (*phone starts ringing*) is there anybody waiting on a prescription?
PA79: me . I'm waiting on prescriptions as well hen
ARA2: (.) what's your name?
PA79: it's Mrs D (.) MD and TD (*woman's and man's names*)
ARA2: (9) what's your address?
PA79: 235 B Road
ARA2: there y'are
08-58 PA79: right . thank you

08-49 RA6: that's you
PA77: thank you
RA6: okay?
08-50 PA77: bye

08-52 *Phone. RA6 arranges appointment for following day.*

10-48 *Phone rings 6 times. RA6 arranges appointment for following day.*

11-24 *NCP*

11-29 *Phone rings 3 times and carries on ringing. RA6 asks caller to hold.*

11-37 *NCP*

11-58 P*hone rings once. RA6 arranges appointment for following day.*

13-37 *Phone. RA6 tells caller that a letter has been sent out to him.*

14-23 *Phone. RA6 asks caller to hold.*

14-26 **F/16-25/lm/em**
RA6: yes?
PA80: hiya . can I make an appointment for the midwife please . for a week today

(*phone rings twice*)
RA6: a week today with the midwife . is it just a:. just an ante-natal clinic?
PA80: yes . just a check-up
RA6: (*quietly*) Tuesday . one week
PA80: (.) with Jean
RA6: right (6) right . I don't know . hold on a wee se:c
PA80: okay
RA6: (.) is the ant- . has that ante-natal clinic no: . been=
RA2: =no it's on a=
RA6: =confirmed yet
RA2: no . it's not <u>on</u> (*phone starts ringing*) it's Friday the t<u>went</u>ieth
RA6: o:h . right
RA2: she's on . holiday
RA6: (.) right . so it's this Friday
RA2: ay:e (.) if there's any left (.) that's the book-in clinic
RA6: no || it's just an ante-natal clinic
RA2: || (several words unclear) is that the . the Wednesday one?
PA80: (.) well . I was at the || hospital this morning
RA6: || Tuesday
PA80: and he's just wanting me to . get a week's ch- . get a check-up in a week
RA2: alright || Tuesday . so next Tuesday . it's not on so it's on this Friday . that's it
RA6: || Tuesday
RA2: the twentieth (.) in the . morning
RA6: oh it's in the morning
RA2: aha . there you go
RA6: ten forty-five
PA80: that's fine
RA6: and your name again?
PA80: it's LM
RA6: (.) LM (10) is it M A C L? (*last letter is initial of woman's first name*)?
PA80: M C C (*clears throat*)
RA6: (2) your date of birth?
PA80: thirty seven seventy-seven
RA6: that's you then . Friday the twentieth at ten forty-five
PA80: that's fine . can I also make an appointment for tomorrow for BM (*man's name*)
15-50 RA6: BM . (*low voice*) right . a wee sec

15-54 *Phone rings 20 times. RA6 asks caller to hold.*

15-59 RA6: right . an appointment for ↑tomor<u>row?</u>
PA80: yes (.) for tomorrow after three || or after two
RA6: || see what I've got
wait tae I see (2) tomorrow after three:
PA80: or two || whatever
RA6: || ten past . er twenty past three
PA80: that's fine (5) || d'you know
RA6: || date of birth five eight seventy-two?
PA80: that's it || d'you know who it's with?
RA6: || that's you . that's- . no . it's an emergency
PA80: that's fine . no problem . thank you

RA6: tomorrow at twenty past three || okay?
16-23 PA80: || okay . lovely . thanks

16-24 *Phone.* RA6 *arranges appointment for following day.*

17-11 *Phone. RA6 arranges appointment for following day.*

17-34 **F/41-60?lm/esm**

RA6: ye:s . hello
PA81: hello dear . I've got an appointment with Dr MacLaverty at four o'↑clock
RA6: okay
PA81: thank you very much
RA6: if you just fill that in and put it in the box
PA81: I will do
RA6: and your name was?
PA81: er S (.) it'll be under MS (*woman's name*)
RA6: right(3) (*quietly*) MS . Dr MacLaverty (1) that's fine {PA81: okay} have a wee seat . he's in room four . okay . just fill that in and pop it back in the box Mrs S . oka:y?
17-57 PA81: okay

17-58 **F/61-75/lm/om**

RA6: hello H (*woman's first name*)
PA82: hiya
RA6: e:m (1) that's you . if you fill in that love and put it in the box
PA82: what's this
RA6: have you got an appointment with Dr ↑MacLaverty?
PA82: aye . who's with him the day?
RA6: (.) you
PA82: nae student?
RA6: n:o
PA82: thank god
RA6: room two and he'll give you a cal
PA82: got to fill this in . have I?
RA6: two se:conds . it'll || take
PA82: || are you male or female!
18-21 RA6: aha hh hh

Practice B, Disc 1: 9-30a.m. Friday 2nd May 2003

01-29 **M/75+/ly/o**

RB1: hi:
PB1: e:h . Dr Peake
RB1: (6) Dr Peake (*faster*) what was your name?
PB1: eh D (*surname*) (.) nine forty
RB1: oh that's fine (2) can I just give you this to {PB1: aye} to fill in
PB1: || s- sure . I've got a pen
RB1: || okay . have you got something . have you got something to lean on? . no?
PB1: yeah . I've got my paper || here love
RB1: || that's fine
PB1: I've got a pen love

01-53 RB1: tha:nks

01-55 *RB1 checks with HH about questionnaires.*

02-00 NCP

02-38 *Phone rings twice. RB1 takes personal call.*

03-18 **M/61-75/lw/esm**

RB1: can I help you?
PB2: nurse: eh . nine forty-five . H K
RB1: (3) that's fine thanks (.) oh (.) Mr K (6) just give you . this to fill in
PB2: this to fill in?
RB1: yeah (.) just want to (.) take a seat and do that . thanks

03-41 PB2: (?unclear) fill it in (?unclear)

03-42 **F/41-60/lw/ey**

PB3: e:h W S's prescription please
RB1: what's the address for that?
PB3: 38 West K Place
RB1: (26) that's . it (.) that's it there (5) that's the prescription . can I just em (.) give you this . to fill in || and just hand it back to us
PB3: || yeah . I'll I'll have to get somedy to read it cos I've no got my glasses || (*breathy*) ha
RB1: || ha ha
HH: maybe they (IA1 & IA2) could help you

04-31 PB3: yeah . I'll go back to them . right . thanks

HH checks that questionnaire numbers are matched with patients. AsksRB1 if PB3 returned his questionnaire to box provided. Says she'll just take them if handed back to R.

05-58 NCP

08-42 **M/26-40/lm/o**

PB4: morning
RB2: morning
PB4: (unclear)
RB2: yeah and then I've to give you that one to fill in for us . if you don't

mind (.) (*faster*) have you got an appointment sir?
PB4: I do (.) nine forty with Dr ↑Peake
RB2: Dr Peake . and what was your name?
PB4: S G
09-00 RB2: (2) that's fine . if you just take a ↑seat . thank you

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09-08 NCP

09-28 **M/61-75/lm/esm**

RB1: can I help you?
PB5: aye (1) this <u>form</u> here
RB1: em right . I'll give you it (8) that's it there . I'll just give you the . the pen . have you come in . have you got an appointment?
PB5: naa . there's something I- . I've got to ask about
RB1: right
PB5: I stay just down the road there
RB1: aye
PB5: I phoned up on . Wednesday morning . I don't know whether you were the receptionist I . I spoke to . it was <u>nine</u> o'clock in the morning
RB1: no: . em . I've been on the desk this week . somedy on . somedy on the phone . what <u>was</u> it?
PB5: well . I got a phone-call fae Dr Dune on Wed- . on Tuesday night {RB1: aha} at half past five (.) I wasn't in but he left the- a message on my voice mail {RB1: aye} so he wanted some information from me {RB1: a<u>ha</u>} medical like . so I phoned up on . Wednesday morning at nine o'clock {RB1: aha} and Dr Dune was speaking to a patient . so I asked the receptionist the . if they w- . if she could . if he . if I could pass it . if he . if she would pass the
RB1: the message || mhm
PB5: || the message <u>on</u> to him {RB1: aye} you know . so I done that and she took . she too- took a note of it you know and (several words unclear) . so last e:h . yesterday at half past twelve I got another . phone-call frae Dr Dune {RB1: aha} I don't think he- he got that information that he'd asked (?for) {RB1: aye} cos he had to phone me back again you know {RB1: aha} wh- what- . what could've happened like do you think?
RB1: she's maybe put . the . all the doctors have <u>mess</u>age books . she's maybe put a message <u>in</u> . maybe he's . just . not looked at it || you know
PB5: || oh I see . aye {RB1: aye} I was j- just wondering like you know . || cos you know
RB1: || aye cos we
PB5: || cos it might've been something important you know
P1 || cos we do give messages through . aye
PB5: aye . I'm just wondering . it's okay
RB1: okay?
PB5: that's alright
RB1: that's fine then . if you want to just give that . a wee fill in for us
PB5: just hand it in here?
11-08 RB1: aye . just hand it back

09-30 **F/41-60/lm/om**

RB2: hi . are you handing that back in? can I give you that? and if you can fill that in for them . is that okay?
PB6: sorry?
RB2: if you can fill that in for us
PB6: what <u>now</u>?
RB2: yeah (.) please . and you hand it back . have you got an appointment? . or:?
PB6: with Dr Dune
RB2: what was || your name?
PB6: || E S
RB2: (9) right . unfortunately it's gonna be Dr Ireland you're seeing this morning . is that okay? we had to change the appointments:
PB6: aye || that's fine
RB2: || there was a problem with || Dr Dune's surgery
PB6: || it's just for my tablets
RB2: you don't mind?
PB6: do I just put a tick on? . do I put a tick on this . aye?
10-14 RB2: (*reading*) please tick . aha (10) (*P returns questionnaire*) thank you

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10-15 *RB2 checks with HH on how to deal with questionnaires.*

11-03 **M/41-60/lm/6 weeks**
RB2: morning
PB7: hi pal . I don't know if it's ten o'clock or ten past ten with Dr Robin Ritchie . er Mr D . B D
RB2: what was the name? sorry?
PB7: D || B D
RB2: || B D (.) it's ten past ten Mr D {PB7: aye} okay . do you want to gie me that || back
PB7: || aye . what happens here?
RB2: ha . did they not explain it to you as you came in? || could you fill that in for us?
PB7: ||aye . I've got to do my (one word unclear) and ↑o:::h . cannae fall out with you (.)
RB2: ha ha . ha
11-24 PB7: (*to NCP*) how're you doing?

11-25 NCP

11-38 NCP

11-58 **M/41-60/lm/esm**
PB8: || hi can-
RB2: || morning
PB8: morning . can I have a repeat prez- . a repeat prescription for Mrs L please
RB2: Mrs L (10) what's the <u>first</u> name?
PB8: E
RB2: E (6) Telford Drive
PB8 and I've to give you that . thanks very much
RB2: I've got another form for you to just fill out . is that okay? . if you hang on a second?
PB8: yeah

RB2: (6) if you don't mind a few minutes just . filling that out for me || please
PB8: || okay .
thanks
12-32 RB2: thank you

12-18 NCP

12-35 NCP

13-19 NCP

13-29 NCP

13-54 NCP

14-10 **F/26-40/lm/twice a month**
RB2: hi: . have you got an {PB9: I- }appointment?
PB9: aye || em wi'
RB2: || who's it with?
PB9: em . Dr Moyles
RB2: (3) L R?
PB9: aye
RB2: (.) that's fine . if I . can just ask you to fill . that out {PB9: right} if you
14-24 don't mind (.) thank you

14-26 *IA1 hands in questionnaire to RB2.*
14-28

16-16 **F/61-75/lm/esm**
RB2: morning
PB10: (?the lassies) have gied me this and they said that you'd give me a for:m
RB2: aha . will do=
PB10: =and I'm seeing the doctor at five past ten . so I hope it's no a very big form
RB2: it's not . it's a small one
PB10: I booked in earlier on and I went to the chemi- . I went to the chemist
RB2: who is it you're seeing?
PB10: (.) I don't know . she did it on that one the:re
RB2: is it the emergency doctor? . || Dr Peake?
PB10: || yes . aye
RB2: J R?
PB10: aye
RB2: okay . that's fine . just take a seat || for me
PB10: || who am I seeing?
RB2: Dr Peake
PB10: (.) Dr Peake . is that a lady doctor? {RB2: aha} is it
RB2: okay?
16-47 PB10: aye

17-26 NCP

17-56 NCP

18-10 **F/75+/lw/em**

RB1: (*to NCP*) hiya (.) (*to PB11*) can I help ‖ you?
PB11: ‖ em . that is a letter from the hospital
RB1: mhm
PB11: for Dr ‖ Bijarnia
RB1: ‖ okay . I'll give that to Dr ‖ Bijarnia
PB11: ‖ and eh . I've got an appointment at quarter to ten . (*faster*) twenty past ten . (*laughing*) twenty past te- . ha ha ‖ ha ha
RB1: ‖ who's it to see?
PB11: to see Dr Anderson
RB1: Dr Anderson . what's your name?
PB11: M H
RB2: right
(*Companion of R2 makes comment*)
RB1: em (.) can I just give you one of . them
PB11: (8) and I've got a prescription to pick up ‖ (*two words unclear*)
RB1: ‖ I'll get that for you as well
PB11: aye . ‖ (two words unclear)
RB1: ‖ would you just like to give that a quick (.) ‖ fill-in
PB11: ‖ I've no got my specs on {RB1: laughs} and I cannae see with these
RB1: can you no?
PB11: no to write anything
RB1: o::h ri- . do you want to just leave it then?
PB11: aye . just leave it
RB1: okay then (1) em . a prescription as well
19-08 PB11: mhm

19-44 (*PB11 is chatting to friend at desk.)*
RB3: can I help?
PB11: (.) e::h . I'm being attended actually
19-48 RB3: okay

20-02 PB11: *(to companion)* it was supposed to be left at the desk . you see what I mean?

20-30 RB1: just gonna check (4) just check the computer=
PB11: =it's for . eh M C (*female name*)
RB1: (.) o:h right
PB11: a:ye
RB1: (14) (?M C's prescription) . alright?
PB11: okay
RB1: okay . thanks
20-54 PB11: thank you . ba-bye

19-49 **F/41-60/lw/ow**

RB3: hi there
PB12: hi . em P (*male first name*) . S (*surname*) for Dr Dune
RB3: for Dr Dune . what was the name? sorry
PB12: P S

R3: (15) is that okay for you? {PB12: right . okay} can I give you that? . just to complete as well
PB12: right . thanks . and have you got a prescription for D S (*male name*)?
RB3: mhm (10) is it N Drive?
PB12: 104 N Drive
RB3: that's it there for you dear
20-27 PB12: right

20-44 **F/ 26-40/lm/om**
RB3: hi . could I help?
PB13: aye . I've got an appointment with Dr Moyles . at ten o'clock
RB3: (7) what was the name?
PB13: S M (2) there's that form
RB3: (.) that's fine S (1) I've got another . just get you to do another form for me S
PB13: right
RB3: (5) can you fill that in for me? . I'll give you that pen there
21-16 PB13: right

22-09 NCP

22-26 NCP

22-48 NCP

23-00 **M/61-75/om/**
PB14: that's for you . I dinnae ken what this is
RB1: o:h r- . right . can I just give you . one of these forms
PB14: (3) what's this? have I to fill this in now? I've nae time . ‖ I'm getting (one word unclear)
RB1: ‖ it's . well it's just . a ‖ quick questionnaire
PB14: ‖ I'll take it and I'll bring it back . kay? . ‖ I'll take it and I'll bring it back
RB1: ‖ can they take them? ‖ take them away?
PB14: ‖ can I get my repeat ‖ prescription?
RB3: ‖ (*loud*))it's happening today . you need to be here today for it
PB14: I'll come back the day then
RB3: no: . it needs to be done ‖ just now not (?doing it)
PB14: ‖ I'm no even sure to be back . I'm in a hurry
RB3: well . we'll just . we'll not bother then . ‖ that's okay
PB14: ‖ aye . I'm sorry about ‖ that
RB1: ‖ did you come for something else anyway?
PB14: aye . I've come to get my prescription
RB1: aha . what was the name?
PB14: C . (*spells name very fast*)
RB1: (20) M Green?
PB14: aye
RB1: okay?
PB14: I dinnae see any sense in . getting it done . it's quite simple . I just

came in and gie you things . and it's (several words unclear)
RB1: aye well . that's fine . it's okay || you don't have to fill it in
RB3: || (*laughing voice*) you'll be
24-01 thinking we're terrible Heather

24-02 NCP

24-11 **F/41-60/lm/esm**
RB3: || hi . can I help?
PB15: || hi . it's to pick up a . prescription please . it's a repeat prescription . H D
RB3: right (28) trying my best (4) are you quite . are you quite happy to fill in that quickly for me?
PB15: yeah . I'll just=
RB3: is that okay?=
PB15: =aha . yeah
RB3: that's your prescription . hold on to that (4) thank you
PB15: that's fine thanks
RB3: take that back from you
PB16: (14) is that it yeah?
RB3: that's it . ha ha ha
PB15: no problem
RB3: thank you very much
25-23 PB15: bye . thanks

24-38 **F/41-60/om**
RB1: hi:: (.) got to . give you another one (7) it's just a research thing
PB16: I've no really got time to fill it in the day cos Tom's standing outside the door
RB1: o:h . right then || do you want to just leave it?
PB16: || right . sorry about this . aye I just want to fill in (? my pres) . I just want to get my prescription
RB1: what-
PB16: H (*surname*) . J H
RB1: J
PB16: sorry about this
RB1: that's okay
25-22 PB16: he's standing out there (19) right . thank you . ta:

25-17 RB2: (*to NCP*) sorry . can I help someone?

25-24 NCP

25-36 RB1: can I help you (*to NCP*)

25-44 RB3: morning (to *NCP*) are you being seen to?

27-37 NCP

27-58 NCP

28-13 NCP

28-34 **M/16-25/lm/2 weeks**

RB2: morning . can I help?
PB17: (.) appointment with Dr Hubble at ten o'clock
RB2: your name?
PB17: C F
RB2: (10) that's fine . if you just take a seat for me sir
PB17: I've to hand that in
RB2: okay (5) (?can you fill out that please)
PB17: right

28-58 RB2: thank you

29-06 *Phone rings once. RB1 answers a query from back office.*

29-20 **M/75+/o/esm**

PB18: (*very careful speech*) can I have . a repeat prescription for M (*female first name*) and Henry Curran (*male name*)
RB1: right {PB18: e:r} can I just give you: . er another research form to fill in ‖ it's just a quick one
PB18: ‖ y:: c- .
okay kiddo:
RB1: (2) thanks very much . it won't take you a minute and I'll . I'll just get your prescriptions for you
PB18: (2) mm:
RB1: (26) (*under breath*) R Mains . R . Mains Close is it? . thanks very much for that
PB18: is that it? is all that there is to it?
RB1: yeah
PB18: painless

30-13 RB1: painless

30-09 NCP

30-14 NCP

31-07 **M/41-60/two months/esm**

RB1: help ye?
PB19: ha ha . I think we're supposed to get a ha ‖ (?gie that to you)
RB1: ‖ I've got another one ‖ for you . it'll only take you a wee second
PB19: ‖ oh . thanks very much . that's great eh? (*woman laughs*) can I hand my prescription in? he he he
HH: it's all my fault
PB19: hehe (2) can I check and see if I've done that (*prescription*) right before I hand it in
RB1: aye. em . I'll just do that for . if you'd just like to . give that a wee . tick ‖ just to
PB19: ‖ I mean . there's only one item and I'm no sure if I've ticked that right or no
RB1: right (.) you just have the one item?
PB19: aye
RB1: is that the only one you're wanting?
PB19: aha
RB1: that's all it is . you just tick the box . it'll be number one

PB19: a:w . right
RB1: that's okay . I'll just check it here . thanks
PB19: I've to fill that in and hand it back to you have I?
RB1: right . aha . if you just do that just now . that be fine
31-46 PB19: ↑hm::::la

33-20 HH: I can take that from you
PB19: surely I could (two words unclear) || ha ha ha ha ha
HH: || ha ha ha ha ha . thanks very much
PB19: right . oh . no (several words unclear)
HH do you want to- ?
PB19: no . I just want to check || ma prescription
33-30 HH: || okay . ha ha

33-45 PB19: will I get that . on Tuesday? || prescription . cos you're shut Monday eh?
RB1: || Tuesday afternoon it'll be . cos we're shut on Monday . aye
PB19: shut on Monday . aye
RB1: okay . thanks very ↑much
33-50 PB19: okay

34-29 **F/75+**
RB1: hi:
PB20: e:h . I've to hand that in
RB1: right . can you hold on just a second (*P20 sighs*) (4) could I just get you to . it's just to do with || that
PB20: || oh they'll have to do it . cos I've no . I've got an appointment for Dr Dune
RB1: aha
PB20: oh they- . they can ha- . fill it in . I've no even got my glasses . my (?bins) . my reading glasses
RB1: okay then . just take a seat for Dr Dune then
PB20: okay || thanks then
35-54 RB1: || bye

35-09 RB1: *Phone rings 1½ times. RB1 says she'll take some papers through to the back office.*

35-28 **M/16-25/lw/o**
RB2: hi . can I help sir?
PB21: yeah . hi . e:m
RB2: (.) mhm?
PB21: (*laughs*)
RB2: have you got an appointment?
PB21: yeah . got an appointment for . who's it with? ten past ten with e:r . was that . Hubble?
RB2: yep . what's you name?
PB21: it's eh . M ↑S
RB2: (4) oka:y . and if I can ask you just to take a couple of minutes to fill
35-51 that out . won't take long . thank you

35-53 **F/61-75/lw/esm**
PB22: got an appointment with the nurse . E L

RB2: (7) that's fine . if I can just ask you to fill (.) that out . it'll just take a couple of ↑minutes
PB22: || a:ye
36-08 RB2: || alright? . thank you

36-09 RB2: Katie (RB1) || where's the (one word unclear)
PB22: || will I just go and sit down out the road the now eh?
RB1: in em . the quiet room opposite M (*Dr Hubble*)
RB2: okay . (*to P*) I'll just take you round
RB1: did you (2) if you just go . through that way . she'll just . yeah . thanks
PB20: (6) here we are
36-28 RB1: right . thanks very much

36-32 *RB1 checks with HH that questionnaires are in order.*

36-55 RB1: || thanks very much
PB22: || right . I dinnae have to sign anything? you know
RB1: no . that's fine
36-59 PB22: right hen

37-24 NCP

37-53 NCP

38-12 NCP

38-40 **M/26-40/lm/om**
RB2: hi there
PB23: hi there
RB2: thanks . have you got an appointment?
PB23: I do . yeah . I've got one at . I believe at <u>five</u> past and one at <u>twenty</u> past
RB2: doctor?
PB23: eh . Dr . (*partner prompts*) Dr Dune
RB2: what's the name?
PB23: it's C B (*male name*) and L E (*female name*)
RB2: (4) that's fine . if I can just ask you . to fill that form in for us
PB23: not a problem
RB2: thank you
39-03 PB23: thanks very much

39-40 NCP

39-53 **M/26-40/lm/om**
RB1: can I help <u>you</u>?
PB23: is that where this goes? . no?
RB1: yeah . e:m . <u>no</u> . it's okay . I'll just take it for you
PB23: alright . no problem
RB1: okay . thanks
40-25 PB23: thanks very much

40-04 RB1: (*to NCP*) can I help ye? . you're okay?

40-05 NCP

40-30 NCP

41-17 **M/41-60/ly/ey**

RB3: can I help?
PB24: (1) (*in an undertone*) (?should probably give you that first)
RB3: o:h
PB24: eh . appointment with . eh . Dr Hubble {RB3: mhm} name's S (*surname*)
RB3: (6) (*fast*) thanks . can I just get you to fill in that one for me Mr S
PB24: yes . aha
RB3: that's fine . your appointment's okay . you can have a seat {
P24: that's fine
41-37 RB3: yeah

41-39 NCP

41-56 RB3: I'll take it over here if you like (*questionnaire*)
PB24: right . that's fine . thank you
41-59 RB3: tha:nk you very <u>much</u>

42-04 NCP

42-55 **F/61-75/lm/esm**

PB25: (*clears throat loudly*)
RB1: (4) can I just em (.) give you this one . to quickly fill in || as well
PB25: || okay then
RB1: did you come in || for
PB25: || e:h . prescription for S (*surname*)
RB1: what's the address?
PB25: 23 G.M. Park
RB1: (22) that's it there (.) || thanks
PB25: || right . thanks very much (1) (*clears throat*) e:m . do I take this away again? . or what?
RB1: no . you just <u>leave</u> them with me
PB25: oh . I just leave them . okay then
RB1: thanks very much for doing it
43-42 P25; right . thank you

44-38 **M/61-75/lw/om**

RB3: hello:=
PB26: =e:h . a prescription for H D
RB3: (.) H D
PB26: a:ye (.) got that er (1) prescription
RB3: (6) are you happy to take part in that Mr D? (*research*)
PB26: eh?
RB3: (*more slowly*) are you happy to take part in that?
PB26: a: aha . it's all the same hen . ha ha
RB3: can I give you that to fill in <u>for</u> me
PB26: no:ho || cos I've no got my glasses on
RB3: **|| will I read it out to you?**
PB26: aye . you || no got my glasses on

RB3: || right . okay so you're male . which a- . age group do you belong to?
PB26: aye . sixteen . four . thirty-two (.) (?thirty two) . I'm a pensioner seventy-two year old
RB3: ha . okay
PB26: right
RB3: when did you last visit the practice?
PB26: I was there last week there for the (?boy)
RB3: you were here last week . okay
PB26: aye . (several words unclear)
RB3: how often do you visit the practice? . once a week? . once a month? || or
PB26: || e:r (.) once a month
RB3: that's you
PB26: okay . right hen . ta
RB3: ha ha || fair swap
45-27 PB26: || that's it done

45-06 **M/61-75/lm/o**
RB1: help you?
PB27: (.) J W to see Dr (?name unclear) please
RB1: (6) W? (5) can I just give you . this to fill in . it's just to do with that
45-27 . it's just a (*remainder unclear*)

46-13 *HH tells RB3 that she's checking the questionnaire numbers.*

48-10 NCP
48-32

48-42 **F/75+/lw/em**
RB3: hello
PB11: eh . I've to get one of these forms to fill in
RB3: o:h right . do you want to get one of these from the-
PB11: I got it – and I handed it in
RB3: oh you got it . right . so I'll give you one of these (2) do you want to fill that in there?
PB11: okay
RB3: and I'll just get that back=
PB11: oh I cannae fill that
RB3: || well I'll do it for you
PB11: || somedy'll need to help me . cos I've no got my reading glasses
RB3: aha . okay . which aich g- . age group do you belong to? . forty-one to sixty eh . or sixty-one to seventy-five?
PB11: I'm eighty-three
RB3: (*smiling voice*) oh . you're eighty-three . good for you . when did you last visit the practice? . was it yesterday? . or in the last week? {PB11: e:h} or in the last month? (.) || did you come
PB11: || no . I think it was the last week I went to || the er
RB3: || last week || okay
PB11: || (two words unclear)
RB3: and how often do you visit the practice? is it once a week? or once a month?

PB11: oh . maybe once a month
RB3: once a month . okay
PB11: (.) is that it?
RB3: (*slow rising tone*) ye::h
PB11: okay . thank you
49-32 RB3: oka:y . ha ha

49-24 **F/41-60/y/esm**
RB2: hi (.) thank you
PB28: (.) got an appointment . er . J's (*male first name*) got an appointment . for Dr Dune
RB2: right . J?
PB28: J S
49-35 RB2: can I give you that form to . fill in (.) thank you

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49-44 **F/61-75/lw/om**
RB2: morning
PB29: hi: . er . I've to pick up a prescription for R A (*male name*)
RB2: mhm (6) mhm (*to R*). aha . no . well . it's okay . there's only Roxanne (RB5) . I can take it (2) ‖ what was the address?
P29 ‖ I've to hand you that . aha
RB2: what was the address?
PB29: R (*male first name*) . er . 70 W D Drive
RB2: okay . I've got another wee form for you to {PB29: yes} quickly to fill out .
50-14 if that's okay (6) okay? . thank you

52-49 *RB1 says she's going for coffee break. RB4 comments that it's freezing in staff room.*

53-21 **M/41-60/lm/esm**
RB2: hi there
PB30: morning (.) er Dr Moyles for half past
RB2: what's the name sir?
PB30: Dr M- . M
RB2: (5) just hang on a wee second (5) that's fine . can I ask you to take . just a couple of minutes to fill that out?
PB30: yeah
53-43 RB2: that's okay . thank you

54-03 **M/41-60/ly/2-3 months**
RB3: can I help?
PB31: yeah . I'm a bit late . (?I want) Dr Ireland . I think it was twenty past te:n
RB3: what's your name?
PB31: K . (*spells out surname*) . J K
RB3: that's fine Mr K (2) can I get you to fill in another f:orm {PB31: aye . sure} questionnaire for me {PB31: yeah} (3?) can you see all that? . see all that . is that . can you see that okay?
PB31: yeah . no problem
RB3: that's fine
PB31: right (.) and just eh . hand it back to them?
54-30 RB3: or I'll take it here if you like . yeah

55-05 *RB2 discuss appointments than RB5 asks RB2 how her computer course went.*

56-47 NCP

57-13 **F/41-60/lm/esm**

RB3: good for <u>you</u> . (*to PB32*) can I help?
PB32: prescription for J K please
RB3: K aha (13) J . can I get you to fill that in for me?
PB32: ‖ I will darling . ta
RB3: ‖ could you? (.) thank you very much . and I'll give you your prescription
(*PB32 chats to NCP while waiting)*
PB32: are you a male or a female . that's difficult (*NCP comments*) last month? . well for a while it was every bloody week nearly eh?
RB3: ha . ha ha ha
PB32: now that I'm back to work I'm back to normal
RB3: you're back to normal . ‖ good
PB32: ‖ eh . I'll put every six months to be on the s-hh-afe side {RB3: ha ha ha ha ha} there y'are darling
RB3: that's lovely ‖ thanks
PB32: ‖ should keep that prescription now that I've filled it in
RB3: aye I know
PB32: bad woman ‖ ha ha ha
58-09 RB3: ‖ ha ha ha

57-26 **F/61-75/lm/esm**

RB2: can I help someone?
PB33: (1) prescription for A G please
RB2: mhm (12) hi: A. that's your prescription
PB33: right hen . ta
RB2: and if I could just ask you to fill that in for us
PB33: right . no problem
57-48 RB2: thank you

58-13 NCP

58-45 RB2: P*hone has rung 8 times. RB3 agrees to do something. Off phone, teels RB1*
59-01 *that the computer's gone funny.*

59-29 NCP

60-39 **M/41-60/lm/om**

PB34: hiya
RB3: hi there
PB34: (.) I've just to gie you that
RB3: oh and I'll give this . I've got something else for you (2) swa:p! . do you want to fill that one in for me ‖ now
PB34: ‖ yep . do it standing here?
RB3: yeah
PB34: my son's got a . got an appointment to see Dr Moyles
RB3: okay
PB33: at . ten forty (1) S H

61-04 RB3: (7) that's fine . that's you in S

60-08 NCP

60-56 **F/41-60/lw/ow**
RB2: morning
61-11 (*P35 inaudible, at other end of counter. Check-in*)

61-12 RB3: are you okay Roxanna?

61-26 PB33: where do you put it? (*questionnaire*)
61-28 RB3: that's it . I'll take it in for you . thanking you

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61-33 D: could someone get the last two (?notes) out for me for open surgery?
RB3: yes sure
D: thanks
RB3: I'll get them now
D: are you manning the front desk today?
RB3: well . we've got so much going on with this reco:rding thing
61-43 (*continues out of earshot*)

61-47 NCP

62-47 NCP

63-57 NCP

64-49 **F/26-40/yesterday/other**
RB3: hi there
PB36: will I gie you that?
RB3: yes . I'll give you one of . the::se . could you fill that in for me?
PB36: yeah . sure
RB3: just like that one {PB36: aha} have you got an appointment today? . or
PB36: yeah . I've got one at er . twenty to ten with Dr Anderson
RB3: Dr Anderson . what was your name?
PB36: D M
RB3: that's fine D
65-06 PB36: okay (.) thanks

65-05 **F/41-60/lm/om**
RB2: hi . can I help? (1) thank you . you got an appointment?
PB37: got an appointment at eh . twenty . ten to eleven
RB2: Dr?
PB37: Dr Anderson
RB2: what was your name?
PB37: A M
RB2: okay . if you hang on just a second for me could you? (6) and if I can ask you . just to take a couple of minutes to fill that part out?
PB37: aye
65-26 RB2: would that be okay? {PB37: aha} thank you

65-48 **M/41-60/lw/ow**
RB3: hello there

PB38: morning . Dr Dune. ten fifty
RB3: mhm . what was the name?
PB38: J L
RB3: can I give you this Mr L and you fill that one in for me? . thank you very much
PB38: (*again unclear. P at other end of counter*)
66-02 RB3: thank you

65-52 **M/41-60/lm/om**
RB2: hi
PB34: hiya . I wonder if I could eh . do a repeat prescription please
RB2: mhm . can find them? || they were here
PB34: || I never brought my card in . I'm sorry
RB2: it's okay . what was the name?
PB34: eh . it's K H
RB2: (3) and the address?
PB34: 176 P Avenue
RB2: (3) who's your doctor?
PB34: Dr Brown
RB2: and what do you need?
PB34: eh . everything
RB2: (.) do you know what it is though? . na?
PB34: the Dihydrocodeine (2) e::m
RB2: (.) will I bring it up on the computer?
PB34: pardon?
RB2: will I bring it on the computer?
PB34: aye . please
RB2: (18) Simvastatin?
PB34: yep . Atenolol (2) and Aspirin (.) and the inhaler
RB2: Salbutomol (4) is that . everything you need? . that's everything you usually get apart frae Fluoxetine
PB34: no . I'll forget that
RB2: okay . that's fine
PB34: alright || when
RB2: || eh . Tuesday afternoon it'll be
PB34: Tuesday at {RB2: yeah} e:::||m
RB2: || it's a Monday holiday
PB34: aye . that should be fine . aye
RB2: is that okay?
P34; I think . well my . original one runs out (.) it's a weekly one on the {RB2: mhm} on the first one there (.) it runs out on Monday . aye Tuesday+
67-17 RB2: =Tuesday . okay

67-21 **F/41-60/ly/whenever**
RB2: morning D
PB39: (1) eh . got an appointment with Dr Dune
RB2: okay . can I . ask you to fill that out?
PB39: yeah
67-28 RB2: that okay?

67-59 *RB2 and RB3 chat about non-work topics.*
68-50

69-40 **M/75+/lw/om**

RB2: morning sir

PB40: morning er . prescription for M R (*female name*) || please

RB2: || R (23) got another wee form for you sir

PB40: right

RB2: (9) could I ask you just to . take two seconds to fill that out for us (.) and that's the prescription there

70-24 PB40: thank you

69-55 RB3: we should all be wearing hard hats in here

70-26 NCP

71-47 **F/41-60/lm/om**

RB4: can I help you?

PB41: eh . the woman says I was to give you that

RB4: aye . give you another one

PB41: and I've got an appointment with (.) Dr Ritchie at ten ↑forty

RB4: (4) ten forty?

PB41: aye

RB4: (1) what was the <u>name</u>?

PB41: L M

72-05 RB4: okay L . that's fine dear

72-10 **M/41-60/lm/esm**

RB4: are you being served there?

PB30: eh . I'm no being . I think I've got an appointment with Dr Shorney for next Thursday/Friday but I cannae mind what day || it's just that I

RB4: || oh right . okay

PB30: I dinnae want it to clash with the nurse if possible

RB4: I'll just check for you

PB30: I think . it's on the Thursday . I think it (.) or on the Friday

RB4: what's your name?

PB30: M (*surname*)

RB4: (1) and your first name is sir?

PB30: G

RB4: G (3) yes . eh . Thursday the eighth at nine o'clock

PB30: right || can I get

RB4: || would you like a card?

PB30: eh . yes please . it's just to let me make an appointment for the nurse and all for roughly || about

Child: || (*sing-song*) one two

RB4: (11) (*clears throat*) hhm hhm (5) em . it was nine o'clock . right . the nurse . same day for you

PB30: yes please (two words unclear)

RB4: see what I can do for you (*sucks in breath and whispers*) dudududududu (*clears throat*) . could you see her at nine fifteen?

PB30: that's fine . yeah

RB4: (5) G . G you said

PB30: G . that's it . yeah

RB4: make sure I've got the right one on here the now . right so that's the same time . nine fifteen

PB30: that's lovely . thank you very much
RB4: and that's for the nurse . okay?
PB30: right . thank you very much for your help
73-35 RB4: right . thank you

73-41 *RB3 suggests that two receptionists go for coffee break.*

Practice B, Disc 2, Track 1: 10-51 a.m. Friday 2nd May 2003,

00-42 **F/41-60/o/o**

RB4: yes dear
PB46: hello . I want appointment for day for Do- . Dr Anderson
RB4: (2) what was the name dear?
PB46: er C W K (*Chinese name*)
RB4: (11) is it . you want to <u>make</u> one is it?
PB46: er . yeah yeah yeah (.) make one
RB4: (.) I'll just see whether I have one (17) right . would you like to come up to (3) I'll just see whether I have one (2) next Thursday . ten thirty?
PB46: (unclear)
RB4: ten thirty
PB46: at ten thirty
RB4: eh . now did you say K?
PB46: yeah yeah . C W K (*says name*)
RB4: (5) what was you:r (.) Christian name?
PB46: K (*says first two letters of name*)- . K (*says name*)
RB4: (3) your Christian name
PB46: K (*says name*) . K (*spells name*)
RB4: that's your surname . I want your Christian name
PB46: a:w . C W || C W
RB4: || Sa- Sa- (6) C (*vowel sound in name pronounced wrong)* W?
PB46: C (*corrects pronunciation*) W . yes
RB4: mhm . mhm (4) I'll just give you a card
PB46: (*several unclear sentences about husband and appointment*)
RB4: is that for <u>him</u> is it?
PB46: for my husband
RB4: that's for your husband (1) you'll need to give me your telephone number in case I can't get an (unclear word) . what was your telephone number?

(Continues unclear)

01-25 NCP

02-22 **F/61-75/lm/om**

RB3: can I give you <u>that</u> one? . could you <u>sign</u> that one for me? (.) have you got an appointment toda:y or?
PB43: yes . em . an appointment with the nurse for eleven o'clock. || G F
RB3: || o- (.) kay
PB43: (8) where've I got to sign?
RB3: <u>don't</u> sign that one . just fill it in || that's okay
PB43: || oh aye
RB3: (.) thank you
PB43: just now have I got to fill it in?
RB3: yeah . could you do it now please
PB43: and I'll hand it back
02-47 RB3: yeah . (*laughing voice*) o-okay

02-48 **F/26-40/lw/o**

RB3: can I help?
PB44: are you next?

PB27: no . you're alright
PB44: (1) e:m . I've got an appointment with Dr Ireland at ten to eleven
RB3: what's the name?
PB44: K F
RB3: (.) can I give you another one for you to fill in for me K quickly(3) do that one for me while you're (1) you're waiting . there y'are . thanks
03-07 K

03-09 **M/61-75/lm/o**
RB3: hi there=
PB27: =can I make an appointment with the nurse please . for a fortnight today please
RB3: fortnight today (3) eh . morning or afternoon?
PB27: morning please . half past ten would be ideal
RB3: half ten (.) let's have a look (.) yep . what's the name?
PB27: W . J W
RB3: first name J (.) will I write it down for you? or
PB27: please . if you don't mind
RB3: yep
PB27: (3) got a full appointment diary you see and you've got to keep it || up to date
RB3: || ha ha aye || got a busy. busy life style
PB27: || ha ha . what you laughing at?
RB3: ha ha ha ha ha (5) that's it there || Mr W
PB27: || right . thanks very much . thank || you
03-43 RB3: || okay . bye just now

04-39 **F/41-60/lw/esm**
RB3: can I help? (.) have you got an appointment?
PB45: I've got an appointment for the nurse
RB3: kay (3) what's the name now?
PB45: M S
RB3: (2) can I get you to fill in another form for me M?
PB45: yeah
RB3: (.) are you okay with this? . do you want me to help you or are you alright with this one? (2) can you fill that in or do you want me to help you with it?
PB45: (.) I fi . I'm I'm . female eh? (.) tick it off
RB3: so which age group are you between?
PB45: forty-one and sixty (2) getting old
RB3: ha . ha ha ha ha . no cheating now withthat one . ha ha ha
PB45: oow . w- what about this one?
RB3: when did you last visit the surgery? were you here yesterday? . or last week?
PB45: I was here today
RB3: || were you here
PB45: || I wasnae here last week
RB3: that's okay . were you.er . here last month maybe? (.) to collect your prescription maybe? (2) that's fine . don't worry about that one . and that (.) e:h . how or of- . how often do you visit the practice?
PB45: n:: no very often .
RB3: right || wait while I just . that's fine

PB45: || only when I- . only when I need a-
RB3: (.) that's fine . that's you (.) || oka:y?
5-54 PB45: ||okay

6-55 **M/41-60/lw/every two months**
RB4: can I help you dear?
PB47: (.) I've to pick up a prescription thanks
RB4: (.) okay . and I'll give you that (1) give you that as well just to . e:r . what was the name dear?
PB47: C . Steven C
RB4: thank you (15) that's the one there S . thank you (*sighs*) o::h
PB47: (21) do I just pass that back to you?
RB4: yes . thank you very much . I'll just fold it and (.) I'll stick it in the box
PB47: oh
RB4: I'll fold it and just
PB47: || right
8-00 RB4: || if you just put it in the box thanks

9-59 NCP

10-32 **F/ 26-40/lm/om**
RB3: can I help?
PB13: ah . I forgot when I was in I was to pick a prescription up for my daughter
RB3: what's the name?
PB13: S M
RB4: (20) can I help you? . are you being seen to?
PB13: || it's
RB3: || what was the first name?
PB13: S
RB3: S (1) M?
PB13: aha
RB3: (12) when did she hand it in?
PB13: e:hm
RB3: aw . there it's there
PB13: eh he . right
RB3: tha:nks
PB13: thanks
11-22 RB3: okay

10-41 NCP

11-01 **M/41-60/lw/om**
PB48: em . that's (? the form for you)
RB4: (.) I'll give you (2) give you this just to tick off . okay?
PB48: (.) before I (.) || see Dr Hubble
RB4: || yeah . just (34) (?is that it finished?)
PB48: yeah
RB4: can you just put it in there thank you . just fold it up the form . thank you very much indeed || thank you
PB48: || that's fine . that's okay (8) can I state my problem please (.) em . I'm actually . making an appointment f- Dr Hubble
RB4: ↓aha

PB48: yeah . in two weeks time
RB4: two weeks . right (2) see what we can do for you (*coughs once and clears throat twice*)
DB1: hi D
PB48: (several words unclear) (*laughs*)
RB4: (*whispers*) right (3) two weeks . morning? afternoon?
PB48: mmmm . make it afternoon
RB4: yeah (.) now . would you like it early . or later afternoon?
PB48: (.) early afternoon || (?before)
RB4: || two thirty?
PB48: two thirty . || (?I think so)
RB4: || his first (.) sorry . what was your name again?
PB48: D (*first name*) (.) || N (*spells African name*)=
RB4: =thanks (.) right
PB48: (4) (*whispers*) okay
RB4: give you a card hm?
PB48: that's fine
RB4: (14) okay? . thank you very || much . tha:nks . by:e
PB48: || okay . thank you
13-05 PB48: bye

13-05 **F/16-25/lw/om**
PB49: appointment at ten past eleven with em . Dr Hubble
RB3: (10) what was the name?
PB49: L H
13-18 RB3: that's fine L . thanks

13-21 **F/26-40/lw/o**
PB44: (?Dr Ireland says I've to get) a housing form at the reception
RB3: yeah (.) what was the name?
PB44: K F
RB3: right K (.) (*clears throat*)
P4: (1) no . I've to get that || he says I've to (several words unclear)
RB3: || oh . you've to collect one here {PB44: a:e} right {P44; a:ye} okay . let me see if I've got any . I had some here (.) the last time (8) there y'are K . there's an extra one . em . to go with it
PB44: does that not go back to Dr Ireland? (3) he says I've just to gie a . call in about seven weeks to sign that for him . no? (8) he says I've to get a housing form frae the reception fill all my details in and put it back . to youse and he would sign the rest of it
RB3: (7) these are the only ones I've got . I don't know what wee ones he means (1) (*inbreath*) e::h labadabaday (.) no I mean he must mean that one then K . fill that one in . do you want a pen? {PB44: aye} you . are you doing it just now?
PB44: aye . aye . eh . I've to cancel my appointment for the eighth . (unclear word) . I think it's next week
RB3: is it? . who's that with? || Dr
PB44: || Dr Ireland . make an appointment for . no next week but the week after
RB3: (1) K F yeah?
PB44: a:ye
RB3: (.) eh . I- I'm only on two weeks at a time K . so I'll not be on for that week ye:t (.) I'm only just onto next week . can you phone up?

PB44: right
RB3: is that okay?
PB44: right . as long as that's cancelled (6) can I gie you this sheet?
RB3: yeah . I'll quickly gie you this one if you give that one to me now . thanks K
PB44: have you get a pen?
RB3: yeah . sure (5) thanks
15-18 PB44: thanks

15-34 *RB4 comments to HH that she needs a haircut*

16-04 NCP

16-30 PB49: does it go?
RB3: I'll take it . that's fine (.) thanks L
PB49: thanks . oh the pen!
RB3: ha ha ha ha ↑ha (.) thanks
PB49: thank you
16-36 RB3: thank you

17-44 *GP asks RB3 how the taping is going. She replies that it's going well.*

18-14 **M/61-75/lw/every two weeks**
PB50: hello there
RB4: hello dear
PB50: em (.) I phoned up this morning to check about (*wheezing laugh*) about the: (1) the prescription . Dr Peake
RB4: aha . what was the name dear?
PB50: and er . we didn't have the right (.) || thing for him to see
RB4: || oh right . aye . I think it was me that you spoke to
PB50: yes (.) so er . my wife's on the last one so (.) they need eh . renewed
RB4: (1) (several words unclear) || there it's there . there it's there
PB50: || I think it tells you on the . (?Misrol) aye (1) it
RB4: what's her name again?
PB50: Mrs . I C (*says name*) . C (*spells name*)
RB4: what's the address Mr C?=
PB50: =it's 36A {RB4: mhm} T Drive
RB4: (4) and they say they c- . they . they're on prescription . yeah?
PB50: oh yes . yes . aye
RB4: (.) because some of them are not . some of them you've got to get in frae the clinic you know (*sucks in breath through teeth*)
PB50: no . no . they're on prescription and eh . she already give us the . needles for them
RB4: oh right
PB50: aye an- . but I think she said I can't give you that without knowing
RB4: knowing what?
RB50: er . one it is
RB4: (*reads out name and quantity of drug)*
PB50: cos I hadn't got the letter back from the hospital yet or something like that
RB4: oh right (26) right (.) you've got everything that's on there (1) oka:y

PB50: || (?and that's just the thing . with it . the)
RB4: || em . I think . everything it says . that I've put down . I think that's everything it says that's (.) that's down there so (.) right . okey dokey . now . <u>when</u> did she see her- . || did she see
PB50: || eh . she . what er (.) || let me see
RB4: || was it Dr Peake you said . eh?
PB50: it was Dr Peake . yeah . em . (?what did he say?) . it's just th-
RB4: now (.) how long will that do her for? . is it
PB50: well . that eh . that . well . <u>we</u> just got it last week {RB4: right} last Thursday she went on to this {RB4: oh right}. we got it last week . and that's it <u>down</u>
RB4: yeah
PB50: em . but they'd been <u>add</u>ing all the time
RB4: right
PB50: em . so . that . that's just a week I think . but I beli<u>e:ve</u> it's supposed to . to last about two or three weeks
RB4: right . okay
PB50: but er . we've got one that . that . that need . we need a
RB4: (.) || I'll give this:
PB50: (.) || we need some for . (?to get some) . for spare
RB4: (.) for spare . right
PB50: yeah . but they don't know how
RB4: I'll try and get it for you for tomorrow if you're passing
PB50: for tomorrow? . aye || that'll do me fine . as long as there's
RB4: || I'll eh
PB50: something {RB4: yeah} before the {RB4: yeah} . it's just for the holiday on . you know . you're closed || on Monday
RB4: ||oh on Mo- . well . we're open for a wee while on Monday yeah . but eh . just a second there (2) that's fine || I'll give this yeah . I'll have this for
PB50: || so you'll get it for . you'll get it for tomorrow probably
RB4: I'll try . yeah . for tomorrow probably
PB50: right . that's smashing || thanks a lot
21-07 RB4: || once we get her file in

21-15 PB50: what do I do with this thing? (*questionnaire*)

21-30 **M/41-60/lw/om**
RB4: yes dear
PB51: ah ha . just need to give you that and . I just want to hand that in for my mother
RB4: (.) || can I just give you that as well
PB51: (.) || I always get . I always get caught with
RB4: (*thin voice*) ha ha ha ha . that's fine . just give it a wee <u>ticky</u>
PB51: a:ye
RB4: thank you . that's for your mum . okay?
PB51: aye it is . aye
RB4: be Tuesday . okay?
PB51: fine . aye
21-47 RB4: thanks dear

21-53 **F/41-60/lw/o**

RB2: morning
PB52: hi there . I've got an appointment with the nurse at (.) twenty past eleven
RB2: what's the name?
PB52: M B
RB2: okay . and can I ask you just . to . very quickly fill that out for us . will that be okay?
22-04 PB51: ( ) aye

Practice B, Disc 2, Track 1: 10-51 a.m. Friday 2nd May 2003,

00-40 *HH comments to RB2 that she almost forgot to set up microphone.*
00-44

01-29 **F/41-60/lm/om**

PB52: eh . have you got a repeat prescription for A A please
RB1: I'll- . I'll just (4) can I just get you to quickly (.) sorry . if you just want to fill in . em . just . quickly . I'll just give you a pen . A A?
PB52: mhm
RB1: (14) that's your prescription there thanks
02-03 PB52: right

02-04 **F/41-60/lm/o**

RB1: can I help?
PB54: eh . got an appointment with em (.) with the nurse {RB1: aha} E Y . quarter to
RB1: (2) that's fine thank- . I'll just ‖ give you
PB54: ‖ got one of them as well
02-22 RB1: (4) if you just want to quickly . f:ill that in . that be great thanks

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02-59 PB54: does that go in without that?
HH: yeah . I can take that . from you . thanks
PB54: right . thanks
HH: thanks a lot
03-05 PB54: thank you

03-10 **F/41-60/lw/om**

RB1: help you?
PB55: (?just to hand that in hen there) (1) eh . this is a letter for my mum frae the hospital {RB1: mhm} and it's been sent to us . and it's Dr Robin Ritchie ‖ she normally sees
RB1: ‖ I'll give that
PB55: (several words unclear)
RB1: ‖ yeah . I'll give it to Dr Ritchie
PB55: ‖ eh . it's got Dr . it's got Dr Anderson wrote on it
RB1: right . I'll give it to Dr Ritchie
PB55: right
RB1: can you just . just want to quickly {PB55: right} fill out that
03-30 PB55: right

04-47 **F/61-75/lw/om**

RB2: hi . can I help (3) hi . can I help?
PB56: em . pick up a prescription for P (*surname*)
RB2: okay . I'll take that . and if you could fill that in very quickly for us? (11) when did you hand the prescription in?
PB56: a week on Wednesday . he says it would be ready
R2; a week on Wednesday
PB56: aha
RB2: nobody else woulda collected it?
PB56: na
RB2: what's the first name?

PB56: E (4) 71 stroke 1 T Road
RB2: (1 min 26 seconds) it wouldn'ta gone straight to the ↑chemist? or (.) what chemist do you use?
PB56: the B
RB2: oh . hold on a second (55) right . that's right . thank you . thanks . by:e (.) your last prescription done here was on the t:wenty-fourth of the fourth?
PB56: (1) that was (.) a week past Wednesday?
RB2: mhm
PB56: aye
RB2: that's in the chemist at B
PB56: is it?
RB2: aha
PB56: I don't know how it got there then cos I al- . I always lift it (.) frae here
RB2: right . I'm really no sh- . I mean I phoned the chemist and they certainly said they'd got one . well they just g- . did one on the twenty-eighth so I take it it's that for Coproxamol, Thyroxin and Ferrous Sulphate
PB56: mhm
RB2: yeah
PB56: (1) so it was . the tablets would be lying up there then? (.)
RB2: I wonder if they're still there . right . hold on (.) presume they are . she never said (16) hi . good morning . it's B surgery again . I'm sorry (.) about E P . I take it the prescription's sitting there waiting to be collected (8) s- . but is it sitting there for her to collect? (5) okay (10)
PB56: I need the Thyroxin you see {RB2: mhm} (2) I dinnae understand that . it's a mystery to me
RB2: (25) hello: (2) right . I'm gonna ask you a silly question . you don't know how it got there? . she says she never handed the prescription in (3) yeah . I don't know (3) I don't think so
‖ cos you're not usually among the chemists we send things to
PB56: ‖ unless I've been . unless I've been harassed
RB2: we've got so many we deal with but not usually B as far as I know (1) strange . okay . okay . no problem . ba-bye. I don't know how it's got there but the prescription's sitting in B for you to collect (.) your medication's there . your tablets are there . so I don't know how it got there {PB56: mhm . mhm} I can only apologise
PB56: it's alright . I dinnae understand it . unless I've . missed a day somewhere
RB2: okay
PB56: thanks very much
10-27 RB2: bye

05-21 NCP

05-32 RB1: hi
PB56: can I hand that back to you?
RB1: yep . thanks very much
PB56: kyu
05-30 RB1: ta

05-55 *RB1 agrees to take some files through to another room.*

06-25 NCP

06-55 **F/41-60/lw/o**

RB1: help you?
PB52: can I have an appointment with the nurse for Tuesday please?
RB1: Tuesday (10) have you just been to see her just now?
PB52: yeah (3) M B
RB1: (7) is it just- . is it for a dressing? or (.) blood? . or
PB52: dressing
RB1: got half past four on Tuesday
PB52: that be fine
RB1: (9) I'll just write that down for you
PB52: (1) I've got a wee car- . aw . you've got one
RB1: aye . I'll give you another (10) that's it ↑thanks=
07-50 PB52: =thanks very much

09-14 NCP

09-34 **F/16-5/lm/om**

RB3: can I help?
PB57: it was just to make an appointment
RB3: mhm . do you want to come up to the top?
(Remainder unclear)

10-20 **F/41-60/lw/om**

RB1: hi
PB58: er . got an appointment with the nurse
RB1: aha (1) what was your name?
PB58: C Y
RB1: (6) can I just . give you this to fill in . it's to do with this . e:m . I'll give you
10-46 a pen for it (5) just give you(2) that one there thanks

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10-29 **No details**

PB59: got an appointment at twelve for s- . sister
RB2: what's the name?
PB59: L (.) W L
RB2: (2) okay . hang on a second (7) can I ask you just to quickly fill that
10-47 form in for the lady

10-47 **M/75+/lm/om**

RB1: can I help you?
PB60: yes . have you a prescription for G please
RB2: (*under breath*)I thought it was gonna go quiet
RB1: (23) that's it Mr G
PB60: ‖ thank you
RB1: ‖ and can I just give you (.) quickly . em . fill in that ( ) for the research
11-23 PB60: this part?

11-19 PB56: who gets this? . does the (?lady get this)
RB1: no it's okay . I'll give it to the girl
11-25 right . okay

12-22 PB58: could you take
RB1: shall I take that from you? (.) thanks very much

PB58: I'm no sure what age group there (several words unclear)
RB1: how . how old are you?
PB58: fifty-six
RB1: that's fine . that's it . thanks
PB58: do I just wait here for the nurse now do I?
12-14 RB1: aha . just take a seat

12-22 **M/61-75/lm/om**
PB61: this is all your fault is it?
RB1: aye || yes . I'm afraid so (.) ha
PB61: || ha ha ha ha ha
RB1: em (.) can I just give you that to {PB61: och} fill in . did you . have you come up for a: prescription? . or
PB61: er . C (*surname*) {RB1: C (*echoes surname*)} E D || Drive
RB1: || R C . aha
PB61: (15) is it ticks are yes?
RB1: (.) aye . just put a tick on them . that'll be fine . and that's your prescription there
PB61: (18) I think that's it eh?
RB1: that's great . thanks very much
RB2: thank you:
13-16 PB61: okay . right

13-56 NCP

14-14 NCP

15-04 **M/41-60/y/ow**
RB2: hi
PB62: er . it's to get the . a repeat prescr .
RB2: || prescription?
PB62: || prescription pal
RB2: what's the name?
PB62: K (*surname*) . G (*first name*)
RB2: okay . could I ask you just to {PB62: aye} fill that out for us?
PB62: (2) (*groans*) (1) it's to put one in actually . just remembered
RB2: to put it in?
PB62: aye . just remembered
RB2: (.) ha . trying to confuse me Mr K? (.) what's your address again?
PB62: 4-9-2 P Road
RB2: and your doctor is?
PB62: eh . Dr (?Ireland)
RB2: (4) and what do you need?
PB62: eh . Paracetomol
RB2: (7) do you get anything else?
PB62: no . that's it I think . aye || y-
RB2: || Tuesday afternoon
PB62: oh . is there any chance of getting it in the morning no? (?cos it's about run out)
RB2: you've run out?
P62; aye . they should've tellt me earlier but they never
RB2: (8) before twelve tomorrow

16-09 PB62: okay . right . thanks

16-30 **M/41-60/lw/o**
RB1: help you?
PB63: er yeah . I've got an appointment with the nurse at twelve
RB1: aha . what was your name?
PB63: er . R E
RB1: (9) that's fine . can I just get you to quickly (.) if you could fill that in for
16-49 us . they're just ticks

16-55 **M/26-40/lw/om**
RB1: help you?
PB64: aye . pick up a prescription
RB1: what's the name?
PB64: M M
RB1: sorry?
PB64: M M
RB1: (12) can I just give you this . quickly to fill in {PB64: yep} and that's your prescription
PB64: cheers
17-18 RB1: there's a pen there . whoop

17-52 PB63: do I leave this here?
17-53 RB2: yeah . thank you

17-54 *RB3 asks RB2 what doctor's note means.*

21-59 *RB3 checks on filing with RB1. RB2 replies.*

22-14 *Doctor checks with RB2 on how filing is done.*

22-49 *RB1, RB2 and RB3 work together to locate a file.*

23-23 **M/41-60/lm/om**
RB2: hi
PB65: (.) can I pick up . eh . two prescriptions
RB2: mhm
PB65: eh . one from B J (*female name*) and one for . J J (*male name*)
RB2: okay
PB65: (6) I'm male . e::h
RB2: (4) B (*female first name*) . B . J (*male first name*) . okay?
23-43 that's it

23-44 *RB2 confirms that patient's prescription is in.*

25-12 *RB3 calls secretary to check that she has a patient's notes.*

26-02 NCP

26-33 *RB2 teases RB3 about missing notes.*

27-33 *RB1 undertakes to find missing notes.*

29-44 **F/26-40/lw/ow**

RB1: can I help you?
PB66: aye . just give you that
RB1: (9) can I just get you to quickly . fill that in . and . what was it . did you come up for a prescription? or
PB66: could I: (.) put in a prescription
RB1: who's it for?
PB66: it's H S . S (*spells surname*)
RB1: (.) what's the address?
PB66: 23 stroke 4 P Gardens
RB1: (3) what is it you're needing
PB66: Regulin
RB1: (4) Dr:?
PB66: Ritchie=
RB1: =Ritchie . Tuesday afternoon for that?
PB66: yeah . that's || fine
30-27 RB1: || kyu

30-32 **M/41-60/lw/esm**

RB1: can I just give you that . quickly to fill in
PB67: aye . sure . aye
RB1: is it a prescription? . or
PB67: yeah . A B
RB1: A B (.) what's the address?
PB67: 4 stroke 5 E Terrace
RB1: (21) that's it thanks
PB67: thank you
RB1: that's fine . I'll just take that from you
PB67: oh right
RB1: okay . thanks very much
31-05 PB67: okay . thanks

30-44 PB66: do I leave that?
30-47 HH: I can take them from you . thanks a lot . that's great

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32-43 **M/41-60/lw/o**

RB2: who's first?
PB63: (.) er . I've got . I've already done that actually
RB2: what can I do for you?
PB63: I've got to make an appointment with the nurse . it's oh . for about two weeks
RB2: two weeks (12) okay . that's Friday the sixteenth . morning or afternoon?
PB63: e:r . morning'll do
RB2: half past nine or half past eleven
PB63: er . half past nine'll do
RB2: okay . and your name?
PB63: eh . R E (4) want to write in on this . do you
RB2: yeah . no problem
PB63: (2) that way I'll no forget
RB2: (6) okay . that's it there
PB63: mm?
RB2: that's it there

PB63: er . sixteenth (several words unclear)
RB2: okay
33-32 PB63: that's lovely . right thanks . ba-bye

33-35 **F/41-60/lw/om**
RB1: can I help you?
PB68: good morning . I wonder: . e:m . I've to pick up my dad's repeat prescription slip
RB1: mhm . with the prescription ‖ or
PB68: ‖ with the prescription in it
RB1: right
PB68: and Dr Dune left . he was gonna do me a repeat prescription . em
RB1: just the wallet?
PB68: just the wallet for myself . aye . and I don't know if that one'll be ready yet ‖ but my Dad's one should be
RB1: ‖ I'll have a look
em . if you want to fill that in
PB68: right . thanks
RB1: what was the name?
PB68: my dad is J P and I'm L ‖ P
RB1: ‖ right
PB68: (19) m::h::
HH: (8) I can take that from you
PB68: that's great . ‖ thanks
HH: ‖ thanks very much for . taking part
PB68: cheers
RB1: (9) that's it . thanks very much
PB68: right . and is my one
RB1: do you want eh?
PB68: oh . that one's ready as well . aye
RB1: aye . that's your one
PB68: oh . that's great (.) that's lovely
RB1: okay
PB68: there's your pen . I think it's running out
RB1: oh right . thanks very much
PB68: right . thank you:
RB1: bye
34-52 PB68: ba-bye now

34-52 NCP

36-10 *R2 takes telephone call about hospital test.*
R1 also on phone with query about notes)

39-06 *HH asks RB2 if she has sore legs by the end of her day's work.*

39-51 NCP

39-59 *RB2 apologises to RB1 because she has to go to a meeting and leave her*
40-10 *alone at desk.*

40-52 **F/16-25/lm/om**
43-14 RB1: help ye?

43-14 **M/75+/lm/esm**

PB70: hello . I've to pick up a: . a: prescription for J T (*male name*) please
RB1: what's the address || for that?
PB70: eh . 23 B Drive (*whistles once*
HH: (20) hi
PB70: hello
HH: I'm . I'm a fellow researcher
PB70: oh yes . right
HH: would you mind doing that tick-off form as well for us
PB70: aha
HH: that be great . thanks very much
RB1: (5) did you say 23 B Drive
PB70: that's it {RB1: that's} thank you very much

43-48 RB1: thank you very much

44-09 **M/26-40/ lm/every 6 weeks**

PB71: (several words unclear) for a repeat prescription for A S please
RB1: can you just hold on a minute and I'll just get that prescription for you (*answers phone which has rung 3 times*) Katie here (.) okay ( ) aye . oh . have you no got any? (.) aha . right . I'll see you later . cheero
PB71: it's no got here every . when I visit my doctor's . I come every six weeks . it's no got it there
HH: em . er . put it . put that one I guess . that be . as close as anything
PB71: that's it?
HH: yeah . brilliant . thanks a lot
PB71: what's the date today again

49-06 *HH asks RB1 about closing time and practice door.*

51-15 **M/26-40/lm/om**

RB1: hiya
PB72: e:h . I've just been to the chemist and I thought it was a monthly . the prescription {RB1: mhm} I was given . but the staff told me that . that was my last one
RB1: right . so when do you need . another appointment for?
PB72: e::m . it'll be today . I need one . but I was aware it was a monthly prescription . I had .(?)
RB1: have you only got enough for . for today then?
PB72: e:h . well he says I need one- . I need . I need my prescription the day cos it's shut on Monday {RB1: mhm} so I assume it's . I'm only getting tomorrow's and eh . Sunday ( ) I'm no sure . I'm no sure actually what he meant . I just rang up and he says I would need a prescription today
RB1: right
PB72: (*clears throat*) excuse me
RB1: who's your normal doctor?
PB72: e:h . it's usually Dr Blood or . Dr Ireland

Practice B, Disc 3: 2-00 p.m. Friday 2nd May 20 2003

R6 heard in background looking after a small child behind the counter and speaking to her father.

00-55 **F/61-75/lw/om**

RB4: yes dear
PB73: I have an appointment with Dr Dune at two o'clock
RB4: *(whispers)* two o'clock
PB73: I'm just on time I think
RB4: right Mrs M
PB73: I've got to hand this form in I think
RB4: oh right . and I'll give you another one
PB73: (5) when do I hand this back?
RB4: (.) just hand it ba:ck . or fold it up and put it in that box Mrs M || okay?
PB73: || alright
RB4: okay?
PB73: okay then . thanks
01-15 RB4: thank you very much dear

01-27 *RB4 calls Chinese patient to explain that she will have to make a new appointment because there is no interpreter available at the time of the one she has already made.*

03-15 PB73: could you have a look and see if my res- . prescription is ready . it was only handed in yesterday morning but it might be ready . er . D M (7) to save me coming back up again
RB4: it's okay=
03-31 PB73: =thanks

05-25 NCP

05-27 NCP

06-10 NCP

06-45 **F/61-75/lw/om**

RB6: hi C
(*PB74 speaks to NCP*)
RB6: ri:ght
PB74: (.) er . I've to fill that in
06-58 RB6: aha . I've got to give you one of these C

07-03 *RB3 and RB4 discuss a work-related problem*

07-09 **F/41-60/ly/esm**

RB4: yes dear
PB75: e:h . I've to pick a prescription up for J W and . put that in there
RB4: (4) (*laughing*) (?could you just . take that) . eh . J W you said?
PB75: yeah
RB4: (7) is that (?unclear word) Drive?
PB75: it is . aha

RB4: okay dear

(RB3 and RB4 continue discussion)

PB75: (21) could I ask . that . that last question . does it mean em . like if you're picking up a prescription . or does it mean a visit to the doctor?

RB4: (2) I think it'll just be (.) it's just

HH: (7) just for anything that you come in for

RB4: anything that you come in for || J . yeah

PB75: || anything at all . a:::w . that's okay

RB4: better to check first

PB75: okay

08-22 RB4: okay dear . thank you very much

HH tells RB6 she will take questionnaires as they come in and discusses how morning went.

09-50 **M/61-75/ly/esm**

RB6: hi there sir . help you with something?

PB76: (.) (*quietly*) e:m . appointment for Dr Dune

RB6: right . okay . can I give you this?

PB76: (.) yes:

RB6: (.) what was your na:me?

PB76: J F (.) I've got a pen in my pocket

RB6: alright . I'll-

PB76: do I just take this and fill it in?

RB6: yeah J . if you have a seat please

10-06 PB76: right . okay

12-28 **M/41-60/lw/om+**

RB6: hi there . help you with something?

PB77: prescription for H (*surname*) please

RB6: (2) just give you this . and take this . what's the first name for the prescription=

PB77: =J

RB6: J (28) what's the address for that one please?

PB77: 54 E W

RB6: (3) here y'are then . okay?

13-10 PB77: thank you

13-06 **F/41-60/lm/esm**

RB4: hi there

PB78:: got an appointment with . eh . Dr Bijarnia

RB4: (2) can I just give you . that one hen

PB78:: (.) thanks=

13-14 RB4: =thanks . (?several words unclear)

13-27 *RB2 points out that one patient in the waiting room should be at adjacent resource centre.RB6 directs patient to centre.*

13-29 NCP

13-58 **M/61-75/ly/ey**

P79W: there's Tina

RB6: hi there

PB79: aye . there's the lass there
PB79: eh . the doctor . Mrs M T for Dr Dune
RB6: ri:ght . M T . filled that in . one to give you
P79W: there's Tina
PB79: there she's there
RB4: hi M! hello:! . how are you?
P79W: no bad (.) I- . I- . I thought you didnae see me when I come in
RB4: no I didnae . I was: chatting and (unclear word) with that man . aye
P79W: (inaudible)
RB4: aha . ha ha ha ha ha: . ha
P79W: hee hee hee
RB4: you still got your sense of humour || anyway .
P79W: || a . hee hee hee
RB4: I can tell you || ha ha ha
P79W: ||hee hee hee
PB79: (inaudible)
RB4: are you alright?
PB79: lots of bother (?with her)
RB4: ha ha ha
P79W: heh heh heh heh heh heh
RB4: ha (inbreath) a: || :h
P79W: || and . how's your knee?
RB4: och . alright || the one th- . the one that
PB79: || what are you wanting . are you wanting a signature on this?
RB4: no no . that's okay . the one that's done's okay . the other one's (unclear word) || (.) but
PB79: ||what are you asking me if I'm alright for?
RB4: I just thought I'd ask you because . you know . I asked . I asked M so I've had to ask you didn't I?
P79W: e:m . || what was it I was going to say?
RB4: || em . but aye . the knee . it's deteriorating but it's . || but I can still walk so
P79W: ||I- . I had the . I had the cortisone in mine . I had the cortisone in mine o- . years ago || (several words unclear)
RB4: ||yeah . yeah . yeah
P79W: but I never got the operation . cos I . I was to get their operation but I never=
RB4: =one of my hips is going as well now
P79W: oh (.) oh
PB79: jigging . that's what it is
RB4: I wish . I wish that Tom would
P79W: hee hee hee hee hee
RB6: (?should ask) by the way
RB4: ha ha ha . ha-ha-ha

15-32 *PB79 and wife speak to somebody in the waiting room.*

RB1 and RB6 heard discuss course RB1 has just been on.

16-22 **M/41-60/lm/om**

RB4: hello || can I help you?
PB80: || good afternoon . got an appointment with Dr Ritchie at . half

past two . er . and it's R H (.) can I give you this questionna- . oh
RB4: yeah . and I'll give you
PB80: give you . a wee questionnaire
RB4: can you just do that one for me as well please
PB80: oh right . okay
RB4: and just fold it and put it back in the box (.) or give it back to me
PB80: ah . right
16-40 RB4: that be fine . thank you

17-03 NCP

RB6 offers HH a sweet. RB3 and RB4 continue to discuss work.

18-14 **M/61-75/lw/om**
RB6: hi there || J
PB81: || ah . you're the one I want
RB6: alright?
PB81: when you're ready like
RB6: I'm ready . what's it for?
PB81: are you sure?
RB6: ↑yea::h (.) can I take that off you and I'll give you one of these
PB81: now like . I've got a wee problem
RB6: you've got a problem?
PB81: now . as you know . we're getting pulled down eh?
RB6: (*yawning*?) aye
PB81: back at W P Street we're all getting pulled down . you know that eh?
RB6: aye
PB81: now it's important I get a house as soon as possible because I believe my neighbour . we've got two on the stair . I believe my neighbour down the stair's got a house (.) they're just waiting || to get
RB6: || did you get your letter then?
PB81: (.) || that's my point
RB6: || (unclear)
PB81: I phoned this morning . I phoned e:h . Wa- . W Place . you ken . the medical place {RB6: aha} and they hadn't received a letter
RB6: well I've got a letter here for you
PB81: you've got a letter?
RB6: wait till I <u>see</u>
PB81: (.) what's that one (several words unclear)
RB6: wait a minute
PB81: oh you've got it . aye? . you've got it?
RB6: this is for you to hand in to the
PB81: the housing
RB6: aye
PB81: really?
RB6: aye . remember I was seeing about . for it . wait a minute (3) that's it
PB81: (.) is there any . is there anything else . is it . is that the thing for the (?operation)? . is that for W Place?
RB6: aye . that's that for:em . remember that for:em
PB81: you said you'd filled it
RB6: the doctor's signed it and filled it in for you and all you've got to do is

hand it to the housing now
PB81: does that entitle me? . does that ent- . title ↓me
RB6: (1) well you'll have to ask them that . but that helps (3) so go and ask them
(*Several exchanges unclear because another patient is also speaking at the desk)*
RB6: no . that's the one . that's the one
PB81: I'm not sure how to do these things
RB6: look (.) that's for the . council ‖ housing and housing
PB81: ‖ oh . I se:: ‖
RB6: for the council . W Place
PB81: so I'm no to wait . I- . I'm no to wait for a letter frae W Place . I wait for a letter frae you . and that's it
RB6: you wait for a letter frae me:: {PB81: and I} to give to them
PB81: aw I see . and I thought I was waiting
RB6: alright?
PB81: sorry (.) sorry
RB6: you just need a stamp on it J . and stick it in a letterbox
PB81: no . no: . just go to the housing there
RB6: you just going to hand it in?
PB81: right away
RB6: that's you sorted than
PB81: thanks darling . really
RB6: let me know how you get on then
PB81: are you wanting then?
RB6: aye
PB81: compliments
RB6: of course J . of course
PB81: (.) thank you very very much
RB6: that's okay . I wondered when you were coming back
PB81: so that's the letter that I want then
RB6: that's the letter you want . for your house
20-31 PB81: thank you . very much

19-32 NCP

19-48 **F/41-60/lw/esm/NNS**
RB4: hi
PB82: eh . I've got an a- . appointment with the nurse at half past ↑two
RB4: (9) can I just get you to . to tick that one as well (.) eh . with the nurse you said?
PB82: yeh
RB4: (2) that's lovely . o<u>ka:y</u>?
20-10 PB82: okay

20-11 **F/61-75/lw/om**
RB4: yes dear
PB73: I've just been in to see Dr Dune but I've lost . I've lost my bus pass . and I don't know if I've dropped it out of my bag in his office . but I think he's got a patient e- . in the now
RB4: okay dear . would you just take a wee seat and I'll
PB73: would you ask him? . it's just where I was sitting ‖ and it might have

RB4: || yep . okay . that's fine
20-24 PB73: dropped on the floor . I'm not sure you know

20-37 RB6: (*to NCP*) are you okay? . is somebody helping ye?

21-17 **F/26-40/o/om**
RB6: hi there
PB83: eh
RB6: give me that one . and I'll give you this one
PB83: right . ha ha ha || ha
RB6: || hahahaha ha
PB83: right . I've to pick a prescription up for I G . please
RB6: I G?
PB83: aye
RB6: (15) right . what was the address for that?
PB83: 15 || (address unclear)=
RB6: = there y'are then=
PB83: =and can I also make an appointment for Dr . Mates . morning . for next week
RB6: right . Dr Mates for in the morning
PB83: aye
RB6: (3) right . nine forty on ↑Thursday
PB83: fine
RB6: who was it for?
PB83: it's . G . S (*male name*)
RB6: (3) I'll just write that down for him . okay? (10) (*aside to HH*) it's alright . Mate . nine forty . Thursday . the eighth of the fifth zero three . there y'are then . oka:y?
22-24 PB83: right . ta

22-25 **M/41-60/today/om**
RB6: hi there . help ye?
PB84: er . Dr Hubble . three . er . two thirty
RB6: aha (.) what was your name please
PB84: R A
RB6: (13) right R . if you just have a seat please . can I give you this other form now (3) here y'are then . okay?
22-52 PB84: (unclear)

22-53 **F/16-25/lm/ey**
RB6: hi there
PB85: (.) eh . I've got an appointment with Dr:: . Robb . at half past two
RB6: `what was your name?
PB85: N S
RB6: (.) right N . that's you down as waiting (.) I'll take that form and I'll give you this one . okay?
PB85: (4) okay
23-16 RB6: thanks very much . ta

22-57 **F/61-75/lw/om**
RB4: Mrs M . no:: (.) we've had a good search in his room while he was out and there's nothing there
PB73: pardon?

RB4: we've had a good search in his room
PB73: (*indistinct recapitulation of information about bag and doctor's desk*)
RB4: yeah . we've looked all over the desk . all under and everything . there's nothing there
PB73: okay
23-16 RB4: sorry about that . okay? tha::nks

23-58 HH: I can take that from you
PB85: alright
24-00 HH: thanks a lot

25-02 **F/16-25/o/om**
RB4: yes love
PB86: hi . I'm here to actually pick up three pres- . prescriptions . one for G J (*male name*) (.) one for G P (*female name*) and one for T P (*male name*). and they're all at five stroke seven‖ (*completes address*)
RB4: ‖ two P and one J
PB86: a:ye
RB4: I'll take that one (.) one P- . two Ps . one Jamieson . right (37) that's it (.) the ↑three . ‖ okay dear thanks
PB86: ‖ that's lovely . will I just hand that back in
25-59 RB4: just fold it and put it in there hen . thank you very much

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26-00 **No details**
RB4: yes dear?
PB87: (.) em . please (.) e:h . I want to see the GP:
RB4: (.) you want to make an appointment?
PB87: if it's possible
RB4: yea:h . w- . next . it'll be next . Thursday or Friday . the first one . or there's . an emergency surgery every morning between nine and ten (1) if it's ‖ urgent
PB87: ‖ okay
RB4: it's
PB87: yeah . actually I'm not sick but I have a form for him to jus:t . complete for me . cos I'm a registered teacher . and they gave me a medical form
RB4: mhm
PB87: that the GP should fill
RB4: mhm
PB87: that's what I ‖ have
RB4: ‖ you've got your . the GP here?
PB87: (.) yeah
RB4: yeah . mhm . so (.) well if it's an emergency we have an emergency service every morning between nine and ten ‖ so you could come in
PB87: ‖ okay . when you say emergency c- . is it possible for him to fill the form for me in the mornings?
RB4: e::r . that's not really what it's for . really oh . you know . you'd need to make an appointment
PB87: ye::s
RB4: you know
PB87: can it be . er . earlier appointment . because=
RB4: =earliest one I've got's next Thursday
PB87: next Thursday
RB4: mhm (.) I'll just tell you when (.) morning or afternoon?

PB87: what time in the morning?
RB4: I'll just check and see who I ha:ve (3) e:h . nine thirty? . or later?
PB87: mhm
RB4: and I can give you Dr Rintoul
PB87: okay
RB4: what's your na:me?
PB87: P (*first name*)
RB4: P?
PB87: E (*African surname*)
RB4: is that it there?
PB87: yes
RB4: E- (*starts to spell name*) right (7) is that E (*spells name*)
PB87: yes
RB4: are you actually registered here or?
PB87: no . I moved in here now
RB4: oh right {PB87: yes} so . I can't give you an appointment till you register
PB87: o::h . so I got to register first
RB4: (12) is it just yourself?
PB87: yes:
RB4: and have you got a house of your own in the area?
PB87: come again
RB4: (*careful speech*) you have a house in this area?
PB87: yes
RB4: (2) if you like to have a seat and fill tha:t: . form in
PB87: er . do I need to confirm with the person because I'm staying with . going to stay with somebody there
RB4: sorry?
PB87: I'm . going to stay with somebody there
RB4: aha
PB87: and . she is registered here
RB4: right . are you staying there permanently
PB87: yes || until I get a place
RB4: || for more than || three months
PB87: || yes
yeah . of course
RB4: so if you fill that in then
PB87: mhm
RB4: we need to get this all filled in before we can || do
PB87: || oh . what time do you close?
RB4: || you
PB87: || so I need to confirm from her (1) then I could come back maybe in half an hour's time
RB4: right . okay . come back at
PB87: yeah?
RB4: close . yeah . we close at six but we: . half past four we do registrations to . oka:y?
PB87: half past four . yeah . I'll be here just now
RB4: okay
PB87: could you keep this for me and reserve the appointment for Thursday? (.) I'll be here just now || it's just near
RB4: || I can't give you an appointment until you're registered {PB87: yes} so if you come back and do the form
PB87: it's just on the street near

RB4: yeah okay . oka:y?
29-00 PB87: okay . thanks

Receptionists talk about "Friday feeling".

32-34 RB6: we're having a wee quiet minute

33-08 **M/41-60/ly/o**
RB4: yes dear
PB88: hiya . what it's . I've to give you that sorry . it's just to pick up a: . a letter . that Mr . er . Dr Ireland's written out for me
RB4: oh . right . can I just give you that as well . just to (.) check off . what was your name sir?
PB88: it's B (*surname*) . S B-
RB6: (3) Tina . can I borrow this for a second: please (1) (*careful speech*) I will give it to you back again
RB4: (8) for L (*male first name*) is it? . did you say
PB88: that's right . yeah
RB4: that's lovely
PB88: thanks very much
RB4: thank you:
PB88: (5) do you want us: . to leave this with you?
RB4: that's fine sir . thank you . thank you || (?indeed)
33-49 PB88: || thanks very much there

RB6 says "just stick it in the box" to patient who returns to desk with completed questionnaire.

34-03 PB89: have I got to . give the questionnaire back . sorry
RB4: the other lady here's got it
34-08 PB89: oh . the other lady's (*calls to IA and CH*) the other lady there's got it

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34-14 *Phone rings twice. RB4 tells caller that this is wrong number and provides right one.*

RB2 makes call arranging to discuss a patient with someone from admin section

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35-40 P79W: cheerio Tina
PB79: (.) cheerio
RB4: bye M. see you dear
35-46 PB79: see you later . cheero

36-19 **F/26-40/lw/om**
RB4: right dear . thanks
PB89: got an appointment with the nurse at quarter to three
RB4: (1) quarter to three?
PB89: aye
RB4: just if . if you just do that now dear (7) must be the other room . right
36-38 C . that's fine dear

RB4 mentions patient's telephone number
RB6 talks to HH about her work

37-16 RB4: (*to PB88*) that's okay C . I've checked y'in

37-14 **F/41-60/lw/om**

RB6: hi there
PB90: hi . got an appointment for: Robin Ritchie at twenty to ↑two
RB6: aha
PB90: or twenty to three sorry
RB6: what was your name ‖ please
PB90: ‖ hhhh . A A
RB6: hh hh
PB90: ha ‖ ha ha ha ha ha
RB6: ‖ ha ha ha ha . right A
PB90: memory's away and a'
RB6: right A . I'll give you w- . this other
PB90: other form to fill in
RB6: ye::s . just a wee tick sheet
PB90: right (.) have I to gie you that?
RB6: (*whispery voice*) aye (.) thanks very much
PB90: e:h
RB6: (2) hello girls
PB90: e:h . last week
RB6: have you been good girls?
PB90: e:h
RB6: for your mum?
PB90: (1) the three lassies? . no
RB6: (.) no?
PB90: nah ‖ they do nothing but fight
RB6: ‖ (*to HH*) the triplets are lovely . come and see
PB90: how often:
HH: can I come and see?
PB90: on average do you visit? eh
RB6: yeah . three girls ‖ three triplets . it must be
PB90: ‖ a:h . I'll say that one (.) there you go
RB6: yeah . it must be easier now though
HH: hhh
PB90: I think if I'd had two lassies and one laddie maybe (.) it's just cos it's three lassies . they just fight . over the least wee thing (.) constant (.) ‖ constant
RB6: ‖ maybe it's cos they're the same age
PB90: I think so
HH: hhhh
PB90: I think so . cos I mean . I had the twins eh . and they're no twenty-five:
HH: hh ‖ ha ha
PB90: ‖ and I mean a laddie and a lassie . you ken what I mean . so: . I had problems with them . but no as bad as that . oh na
RB6: (.) you know what women are like
HH: (.) next time it'll be four
PB90: oh no . no way {HH: hh hh ha ha} no . I'm not going through all that again . no way . ha ha ha
RB6: aye . you could have four A . that would be nice
PB90: no . dinnae . that's what my father says . he says you've had
RB6: I wond-

PB90: he says ‘you had S’ . he says ‘then you had two. he says ‘now you’ve got three . when’s the four?’ . and I’ve went ‘forget it . no way’
RB6: that would be nice (1) we’ve not got four
PB90: (.) my grey hairs are coming quick . fast and furious
RB6: haha ha haha
PB90: I’ll be white-headed
38-40 RB6: ha ha ha ha ha

38-42 RB4: I’m away to . er . try and phone Mrs M . we’ve got her . eh . bus
38-46 pass . found it

38-47 RB6: (*to HH*) aren’t they lovely? (*triplets*)

38-59 RB4: I’ve just left that there . I’ve to keep trying her on the phone

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38-59 PB84: e:h . can I get another appointment with Dr Hubble in two weeks please
RB4: (8) right (.) fine . e:m . two forty? . or later?
PB84: that’s lovely . that’s fine
RB4: what was the name . ↑please
PB84: R A (4) can I get a wee ticket off you
RB4: right
PB84: (several words unclear)
RB4: date of birth sir
PB84: twenty-five seven forty eight
RB4: (2) there we are (22) oka:y? . thank <u>you</u>
PB84: that’s lovely . thank you very much
RB4: thanks dear
PB84: (1) cheerio now
39-54 RB4: cheers dear

40-14 RB6: five . eight . ninety-seve::n

Banter between RB6 and RB4 about ‘boob’ size.

40-34 NCP

41-17 NCP

41-48 **M/61-75/lw/o**
RB4: hi: . hello
PB91: (?got an appointment) for Dr Dune
RB4: thank you
PB91: (?I’m handing that in there)
RB4: can I just get you to tick that one Mr S
PB91: (inaudible)
RB4: (inaudible) ( ) oka:y?
PB91: that’s your pen eh?
RB4: thanks dear . ta
PB91: is the box out here for putting this in?
RB4: I’ll . I’ll fold it for you Mr S . thanks dear (.) I’ll do it
PB91: (several words unclear)
RB4: thank you very much indeed

43-01 PB91: eight . that's lovely

41-55 **F/61-75/lm/esm**

RB6: hi
PB92: hi (.) I have an appointment with the sister at quarter to three
RB6: what was your name please?
PB92: eh . N J
RB6: right then . I'll just book you in . can I give you this now?
PB92: thank you
RB6: o . kay
PB92: will I just go and
RB6: (*high pitch*) yeah

42-15 PB92: thank you

42-16 NCP

43-10 **M/26-30/lm/e6weeks**

RB6: hi there
PB93: pick up repeat prescription for F K
RB6: okay then (.) get that for you (12) can you tell me the address for that
PB93: 78 P Drive
RB6: (.) right . can I give you one of <u>these</u>? (1) tick that off (1) okay ↑then .

43-37 there's the prescription . thank you

43-40 NCP

44-18 PB93: put it in this?
RB4: yeah
PB93: (4) there y'are
RB4: thanks very much
PB93: cheers

44-27 RB4: bye

HH explains to RB6 why she is checking questionnaire numbers.

45-19 **F/61-75/lw/esm**

RB6: hi there (5) can I give you this (1) what can I help you with?
PB94: eh . I just wanted to see if my prescription's ready (.) E L
RB6: a<u>ha</u>
PB94: it might not be
RB6: I'll check for you
PB94: but while I'm here I thought I'd check
RB6: (4) e::m (.) when was it put in . E?
PB94: yesterday
RB6: right
PB94: that's what I'm saying . it might not be ready
RB6: no . it won't be here until tomorrow morning
PB94: okay
RB6: if you come up before twelve
PB94: yeah . it's just that I was handing my sister-in-law's in {RB6: aha} so I thought that I would just check anyway
RB6: || okay then
PB94: || I just tick do I?

RB6: yeah
PB94: oh . tick . yeah (22) oof: (22) (*mobile phone rings*) hello (.) yes (1) I'm at the doctor's surgery at the moment (2) why? (.) I'm just handing in M's prescription (5) yes . so I see (2) yes . I want to . I want to talk to you about that (2) well I wondered what it was (.) okay (2) aye I
47-24 know . okay (3) okay bye (.) okay bye

47-18 **F/41-60/lm/om**
RB6: hi there
PB95: hi: (.) em . I've just to hand you that in
RB6: now . I'll just do a swap with you . you can have that one now
PB95: okay . now I've not got the reading glasses with me so I hope it's no too small (.) em . I've actually just to hand this in for my mother . and I normally just put it in the box {RB6: right} handing it in today . how soon can the chemist pick this up?
RB6: (.) || you'd like it on Monday?
PB95: || because it's the holiday . aha
RB6: we are open on Monday {PB95: right} (.) until twelve of clock . so it would depend if he had sent somedy up . or not (.) which chemist is it?
PB95: it's just the one down the road here
RB6: well . they're normally quite good so if you
PB95: right (.) so it could be Monday or Tuesday he'll get it {RB6: yeah} it depends
RB6: is that soon enough?
PB95: well she said she's got enough to do her I think until Wednesday
RB6: well that be plenty time
PB95: okay
RB6: plenty time . okay?
48-07 PB95: that's fine . right . okay

47-56 **F/61-75/lm/esm**
RB5: hi
PB96: Mrs N . it's eh . ten to three for Dr Dune
RB5: okay . can I just give you that one
PB96: yeah
RB5: (3) (*to HH*) is it okay to do it in red pen?
HH: yeah
RB5: sorry . what was your name again?
PB96: A N
RB5: and it was for Dr?
PB96: Dr Dune
RB5: Dune (25) you can just put it in the box
PB96: alright
RB5: or: you can give it to us . okay?
PB96: right
RB5: thank you
48-43 PB96: okay

48-30 PB95: kay . do you want this? . what do I do with it?
RB5: yeah . thanks
PB95: okay (.) thank you
48-36 RB5: thank you

48-38 RB6: hi . help you with something?

49-08 PB90: see you later . ha || ha ha
RB6: || by:e . ha ha
PB90: cheerio:
RB6: ha ha ha ha (1) aye . they're all happy (.) they're lovely (3) lovely
HH: (2) nice mum
49-23 RB6: (1) happy

RB2 asks if RB1 is at coffee.
RB6 tells HH about filing work.
RB6 is checking if a patient is registered because she can't find her notes.

53-00 **F/26-40/lm/om**
RB6: hi there
PB97: hiya . I've got ad appointment with Dr Robb . ten past three
RB6: aha
PB97: K S
RB6: what was your name?
PB97: K S
RB6: (3) K S . ten past three . that's fine K
PB97: and is there a prescription for . Mrs: K?. E K
RB6: I'll have a look for you (10) right . nothing back yet . but they're coming back just now . so if you ask on . before you leave
PB97: when I come out
53-33 RB6: okay

53-34 **F/41-60/lm/om**
PB98: hi . I've got an appointment with Dr Robb
RB6: what was your name?
PB98: Y C
RB6: (.) Y (1) right . that's fine Y . I'll give you another for:em . this
53-50 one is a (.) sorta tick one . swop you that for that . okay

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53-52 NCP

54-17 **F/41-60/o/o**
RB3: can I help?
PB99: I've got an appointment to see the doctor at three o'clock (.) Dune
RB3: what's the name?
PB99: L M (.) Dr Dune at three o'clock
RB3: right . have a wee seat
PB99: right then
RB3: (1) oh . I'll take that off you
PB99: oh have you
RB3: have you . have you completed that one? (1) that's great . I'll take that
54-35 off you . thanking you

54-36 **F/41-60/o/o**
RB3: can I help?
PB100: (1) can I give you that
RB3: can you complete <u>that</u> one for me . it's just a wee tick-off form and you've to make one (.) when is it you need to be seen?

PB100: em . today if possible ( ) no?
RB3: we don't have anything until about next Wednesday
PB100: right . because you ken (.) I kinda work from day to day . cos I work for somedy else and they tell me what they want . so: . it's awkward for making an arrangement
RB3: right (1) (several words unclear) . the only alternative I would have would be an open surgery in the morning . if you wanted to come to that=
PB100: =is that tomorrow morning?
RB3: between nine and twelve
PB100: or Monday?
RB3: yeah
PB100: is there ay chance of seeing the nurse today then?
RB3: she's not . she's not available this week . we don't have her either . listen . it will be an emergency surgery on Monday . if you wanted to pop up to that one
PB100: em
RB3: that might be easier for you
PB100: (unclear)
RB3: alright . a:lright
PB100: I'll pop up in the morning
RB3: that be okay?
PB100: yeah . thanks
55-37 RB3: okay then

55-43 RB3: Sharon (*RB6*) . have a nice holiday
Explains arrangements for Saturday surgery, the following day.

55-45 **M/41-60/lm/esm**
RB5: hiya
PB101: hi . I've got an appointment with Dr Bijarnia for er . ten to three
RB5: right . okay . can I give you that one?
PB101: (1) mhm (.) that's alright . I've got a pen thanks
RB5: you've got a pen? . okay . and you can put it in there or give it back to me (.) and it was with Dr Ireland?
PB101: Bijarnia
RB5: Bijarnia . sorry (1) what's your name?
PB101: er . C (*surname*)
RB5: (8) Terence (*first name*)?
PB101: that's right
56-14 RB5: yeah . have a seat for me . thanks

56-03 **F/26-40/lw/o**
RB6: hi
PB102: hiya . I've got an appointment with Dr Moyles . please . at three o'clock
RB6: aha (1) can I just swap you this bit of paper for that one . right . what was your na:me?
PB102: it's N C
RB6: ( ) N C. Dr Moyles at three o'clock (.) that's fine N . if you just
PB102: right
56-20 RB6: have a seat please

57-48 **F/41-60/o/esm**

RB6: can I help you with something?
PB103: e:h . got an appointment for . three o'clock . Dr Bijarn- . Bijarn‖ia
RB6: ‖ aha
PB103: M L
RB6: take that one from you (.) M A (*surname wrong*)
PB103: L (*corrects surname*) (.) ha ha ha
RB6: (3) there y'are M . I'll give you a (6) that's fine
58-11 PB103: kyu

58-16 RB6: are you both together yeah?
58-18 PB103: yes

58-19 PB103: that's terrible . forty-one to sixty . makes you sound older

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58-35 **F/26-40/ly/esm**
RB6: hi there . can I help you with ‖ something?
PB104: ‖ hi . er . H R for . Dr Hubble please
RB6: yeah (1) do you want to give me this?
PB104: am I leaving it with you?
RB6: this is true H (.) if I just give you that and I'll book you in . okay? (2)
58-51 that's fine

59-46 NCP

59-59 **F/26-40/lm/om**
PB105: hi . I've got an appointment for C A (*male name*) . three o'clock . Dr Hubble
RB6: aha (4) that's fine . could you fill that in for us?
PB105: aye
RB6: and I'll give you (1) one of them
60-14 PB105: right . cheers

61-16 **M/61-75/lm/om**
RB6: hi there
PB106: hello there (.) I'll gie you that first ‖ eh
RB6: ‖ yeah . can I swap you and give you . another one
PB106: another one
RB6: right . I'll give you this one
PB106: right dear
RB6: and have you got an appointment . today?
PB106: I- . I've got an appointment for the . for the nurse
RB6: aha
PB106: for . for Tuesday . but I got a letter this morning . to get a heart and that . so . I just wonder if I could do it at the same time (.) can I . you ken . do blood pressure
RB6: right (1) have you got the w- . letter with ye?
PB106: (.) no . I've left it in the house
RB6: right . that'll be for a s- . you see this appointment with the nurse . can I ask you what . you've got this appointment for?
PB106: yes . that was for an injection
RB6: right (.) the one that you've got the letter about is a special clinic . you ken . they're monitoring certain things

PB106: oh I see . yeah
RB6: and that would be a separate appointment
PB106: aye
RB6: so I'd have to give you an . a separate appointment for that (.) I could make it for you now
PB106: yeah . I'll do . just do that . yeah
RB6: oka:y?
PB106: yeah
RB6: it's just it's for . that's a ten minute appointment
PB106: aha
RB6: the one you've got just now . so (.) I'll just . it was for extra appointments (.) I'll see what I can give you . oka:y?
PB106: mm
RB6: (11) r- . I've not got anything for tha:t clinic (3) f:or maybe a few weeks (3) . e::m (7) still just checking for ye
PB106: mm
RB6: (2) Friday the sixth of June . in the morning
PB106: Friday? (.) tha . tha . that'll do || fine
RB6: || is that okay for ye? . now I could give you ten past nine (2) or: . nine forty: . or . ten past eleven . or || eleven forty
PB106: || ten past . ten past eleven (.) dear
RB6: (3) right . it's just that these are half an hour appointments cos (.) you'll be getting tested
PB106: I see
RB6: and it takes a bit lo:nger
PB106: aha
RB6: now what was your name again?
PB106: er . J C
RB6: (9) I'll write it down on this card for you J
PB106: aha
RB6: (24) right . there y'are J . oka:y?
PB106: yeah . alright thanks
RB6: right . that's your two appointments . you've one for Tuesday and you've one for Friday
PB106: one for . the . Friday
RB6: oka:y?
63-56 PB106: okay . thank you

64-02 *RB6 hums one line of a tune.*

64-14 R106: I'll just leav- (.) I'll just leave that there dear
RB6: right . thanks very much
PB106: right dear . thanks
64-19 RB6: by:e

64-35 **F/61-75/ly/ey**
RB5: hiya
PB107: hi
RB5: (.) || right
PB107: || it's: . M (*female first name*) and G Burrell (*male name*)
RB5: (.) for:?
PB107: eh . Dr Moyles . ten past three and twenty past three || I think

RB5: || okay . can I get you to || complete that form
PB107: || shall I do that just now?
RB5: yeah . you can do . you can put it in there or give it to us . oka:y? (.)
65-00 right (7) it was G and M wasn't it? (.) yeah

65-05 RB5 asks RB6 if she has packed for holiday.
Discussion of tanning between RB5. RB6 and HH. Suntan lotion. R6's slow tanning,

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65-58 **F/26-40/lm/om**
RB6: hi there
PB97: (.) hi: . is Mrs K's prescription ready? .
RB6: it was E wasn't it?
PB97: aha
RB6: (62) right . there's nothing been done since the twenty-fourth . of April . now was that one picked up?
PB97: (.) mhm
RB6: (.) well nothing's been done yet . d- . do you remember what it is she wanted?
PB97: (.) no . I dinnae (1) what a bloody woman
RB6: ri:ght (.) e::m . did she say she's requested again?
PB97: as far as I know . aye
RB6: would you like to check with her (.) or:
PB97: || right . I'll check with her . aye
RB6: || or get back to us . or do you want me to give her a buzz? (.) and see . I mean I could always give her a phone for you and
PB97: could you?
RB6: aye . what was her number?
PB97: oh . I dinnae ken . e:m . three three two: (1) wait . he's got it in this . (*louder*) oh . I'll phone || her
RB6: || okay || then
PB97: || and I'll pop back in
67-52 RB6: let us know then . oka:y? (.) bye now

67-53 **F/26-40/today/when sick**
PB108: hi there . I was to || bring this
RB6: || well I'll give you a swap . (*quieter*) I'll give you a swap right? . that that and that . now . what can I help you with?
PB108: em . I've got an appointment with Dr Dune . ten past three:
RB6: aha . what was your na:me?
PB108: it's K (*initial*) Ramage (*surname*)
RB6: (2) ten past three (*to RB5*) Roxanna . are we going? (6) that's fine
PB108: (1) that ev- (.) will I . will I fill this in?
RB6: yeah (.) thank you
68-20 PB108: thanks

F/26-40/lw/esm
P109. *Mainly inaudible at far end of counter.*

69-28 **M/26-40/lw/esm**
RB4: yes dear . can I help you?
PB110: yeah . I've got an appointment for . ten past three I think
RB4: what doctor?

PB110: er . pass (.) dinnae ken
RB4: is that || for
PB110: || I never . I never come here very often . once in a blue moon . so I dinnae even ken who my doctor is (.) || I think it's er
RB4: || can I give you that to
PB110: I think it'a er:r (.) Bijarnia I think
RB4: thanks dear . ta
PB110: (4) am I male or female? . can you tell me?
RB4: (2) hard to know
PB110: (.) och . I'm in the sixteen to twenty-five category eh? (3) when did you visit? . Jesus . last year
RB4: (10) okay? . just have a seat
70-19 PB110: aye . nae bother .cheers

70-23 **F/41-60/o/esm**
PB103: can I make an appointment with the nurse for three weeks time . two weeks . aye
RB4: (10) now . what suits you. morning or afternoon dear? (2) what suits . morning or afternoon?
PB103: oh sorry (.) afternoon please
RB4: (3) e:m . two fifteen or later?
PB103: no . that's fine . two fifteen
RB4: (2) sorry . what was the na:me?
PB103: Lyman (*pseudonym*)
RB4: (.) Simon
PB103: Lyman
RB4: Lyman . sorry
PB103: ha ha || ha ha . he he
RB4: || ha ha
PB103: Pyman
RB4: what's your first name dear?
PB103: M
RB4: (.) would you like a card?
PB103: yes please
RB4: (3) pen (.) pen's finished (1) get another one eh? . a:nd . that's the nurse
PB103: (6) (*coughs*)
RB4: (15) oka:y?
PB103: lovely
RB4: thanks dear . ta::
PB103: thank you
71-42 RB4: (.) tha:nks

71-46 RB4: that's nine for Monday

70-29 **F/61-75/lm/esm**
PB111: it's just er . I've got to hand that one in and get a questionnaire
RB1: right . what was your….
(*Rest inaudible at far end of counter*)

72-28 *RB4 talks to RB1 about whereabouts of pen she has lost.*

Practice C, Disc 1: . 8-30 a.m. Friday 17th October 2003

00-46 **F/26-40/lw/om**

RC2: hi there
PC1: got an appointment with Dr Na:sh . it's S L. (several words unclear)
RC2: (.) could I ask you when you get a moment {PC1: okay} if you could fill . in:
PC1: (.) yep
RC2: and . it just goes into the box there (?on that desk) (1) eh . Dr Nash
PC1: yeah
RC2: and your name . is?
PC1: S L
RC2: that's fine . if you'd just like to have a seat || thank you
01-08 PC1: || thank you

01-11 *RC2 discusses research procedure with HH.*

01-45 *RC1 deals with telephone cancellation. Phone doesn't ring out*

02-06 NCP

02-19 *Phone rings once. RC2 arranges appointment.*

02-21 **F/75+/lm/esm + husband**

RC1: can I help you
PC2: oh . here we are . (?that's right)
RC1: (2) I'll give you one
P2H: (.) Dr Green
RC1: Dr Green . hold on a moment (2) Dr Green . and you're giving . your consent . for the
PC2: I'm not quite sure what it's . what exactly is it?
P2H (several words unclear) long . long . long . long . standing
RC1: if you'll just take that . the lady over there will be able to explain what it is
PC2: I don't think I've got
RC1: no that's (several words unclear) that's different
(*P2 speaks to her husband*)
02-52 RC1: I'm sorry about that

02-59 *Phone. No ring. RC1.*

03-56 NCP

04-14 *RC1 calls health visitor to say that NCP is in for appointment.*

04-27 NCP

RC1 and RC2 talk to IA. and HH about research.

07-05 RC1: hello

07-07 **F/26-40/lw/om**

PC3: hi . I've got an appointment . er . at five to nine . my name's J G
RC2: (.) and who's your appointment with?

PC3: I've forgotten . I'm sorry . it's . I think it's a male doctor if that=
RC2: =male doctor (.) five to nine . J
PC3: Wallace or?
RC2: (3) oh . it might be the locum today (2) no it's not (5) could I (1) what's your . er . date of birth ‖ please?
PC3: ‖ eleven five seventy-four
RC2: (11) it's with . er . (? it might be) eight fifty-five with the registrar (several words unclear) . there we are . that's fine . e:h (2) would you
08-07 like to see that lady (*IA*) first {PC3: mhm} over there . thank you

---

07-56 **M/41-60/lw/ow**
PC4: (several words unclear) this morning (1) thank you=
RC1: =there we are . and if you just have a seat over that way please ‖ it's for
PC4: ‖ can I borrow one of the: pens please to
RC1: yeah . that's fine
PC4: fill this in while I'm waiting
RC1: yeah
08-04 PC4: thanks very much

08-20 *Phone rings 4 times. RC1 cancels appointment.*

09-18 RC1: (*to P3, who is handing in consent form*) right . we give you that to fill in . alright? . that one

---

09-26 **F/26-40/lm/esm (Spanish speaker)**
RC2: yes . may I help you
PC5: yes . I've got an appointment
RC2: and who's your appointment with?
PC5: eh . Dr Green
RC2: Dr Green (18) and your name <u>is</u>?
PC5: M H
RC2: that's fine . okay . if you'd just like now . just a moment ( ) have you seen the lady over there? (1) right
PC5: go over there?
10-03 RC2: if you go (.) yes

10-41 **M/41-60/ly/ey**
PC6: ‖ hi
RC2: ‖ morning
PC6: any chance of an appointment for a doctor this morning?
RC2: not for . o:h (.) just a moment (.) I've got an app- . a cancellation at nine o'clock=
PC6: =yeah . I'll take that
RC2: with Dr Murray Browne (1) could I ask your date of birth please
PC6: oh yes . (er) . one seven fifty-five
RC2: (2) and your name is?
PC6: it's er . S P . P (*spells surname*)
RC2: (5) alright (.) if you just (4) right . erm . would you like to see the lady
11-22 over there first before you see the doctor {PC6: yes} thank you

---

11-16 **F/41-60/ly/esm**
The opening is unclear.

RC1: there you are
PC7: and what do you get?
11-27 RC1: I get . your consent please . and I give you one of those (.) thank you

---

RC1 helps RC2 with admin.
RC1 assists PC6 with consent form and questionnaire.

12-49 **M/41-60/lw/om**
RC1: hello:
PC8: (.) hi
RC1: thanks . lovely ‖ you can have that
PC8: ‖ right
okay . that's good . thanks . it's er (*gives name*) to see Dr Glasgow
RC1: (3) right . lovely
PC8: ‖ that's good
13-04 RC1: ‖ just have a seat now in the waiting-room . please

---

13-16 *Phone rings once. RC1 arranges appointment.*

13-46 *Staff visitor arrives and signs in.*

14-21 **F/41-60/lw/o**
RC1: hello:=
PC9: =hello:
RC1: ‖ got to give you this
PC9: ‖ (? I've got an appointment) with the nurse at nine o'clock
RC1: and your name please?
PC9: L R
14-34 RC1: (4) lovely . if you'll just have a seat {PC9: thank you} that way please

---

RC1 explains to RC2 how she is numbering the consent forms

15-35 NCP

15-37 NCP

16-31 NCP

16-49 **F/16-25/lm/ey. (Spanish speaker)**
RC2: yes. may I help you?
PC10: (2) er . I have a doctor's appointment now at nine and then another one with the nurse at nine thirty
RC2: (.) right . could I give you (4) what time's your doctor's appointment .
PC10: the doctor is at nine
RC2: and who is it?
PC10: er . I don't know
RC2: (.)er
PC10: (2) it's the first one
RC2: (4) right . could I ask your date of birth please?
PC10: ninth of August nineteen seventy-nine
RC2: (9) and is it . e:h . M C
PC10: yeah

RC2: (7) nothing coming up for that . I wonder if it's (7) you're certain it's with the doctor? . it's not (1) oh right (.) you've to register . you're seeing the doctor at nine o'clock
PC10: (.) yes
RC2: so you haven't filled in one of these?
PC10: I have . because I saw the nurse the last time I came . but || I didn't
RC2: || did you have your new patient health check?
PC10: (2) I just . I . I saw the nurse and then she told me to . to make a doctor's appointment . and I'm going to see her today: . at nine thirty
RC2: ( ) well it's got here . e:h (.) it's actually the nurse you're seeing (.) today: . e:h (.) and you're seeing the doctor (.) right . have you . have you had any of these forms?
PC10: yeah
RC2: you've filled all these in?
PC10: yes . like v- . various ones || isn't it (several more words unclear)
RC2: || yes . a questionnaire and that . you've done all that? . okay . right . so you're actually seeing . eh . the doctor first . Dr Nash . and then you've got the nurse at nine thirty for blood . right (4) it's got here 'to register' (.) are you sure you've filled in one of these? (.) right . if you just . okay . I'll book you in . alright? . if you || just
PC10: || even so . I'm not sure if it was that . that . er
RC2: well I've got down here that you're to register (.) which means . would you like to fill that out (1) you're not sure whether (2) did you fill in one of these?
PC10: yeah . those I did . yeah . but I'm not sure about this one (several more words unclear)
RC2: well that's your registration form so if you got one of these you would have had . but could you fill that out anyway . because
PC10: okay

19-50 RC2: (1) M C

17-40 NCP

19-10 NCP

19-20 NCP

19-26 **F/41-60/y/esm**

RC1: hello: || can I help you
PC11: || hi cheers Matt . see you
RC1: (?I'll just take) this one . and I'll give you that
PC11: cheers
RC1: and who are you seeing this morning?
PC11: nobody . it's the letter . for . er: . E (*surname*)
RC1: (3) there you are
PC11: that's wonderful || thank you very much
RC1: || everything's fine

19-42 PC11: cheers . thanks

19-43 **M/75+/ly/em**

RC1: can I help you
PC12: hello . yes . nine o'clock . Dr Green
RC1: right . I'll give you that (5) Mr M?
PC12: (two words unclear)
RC1: just have a seat in the waiting room {PC12: fine } please
PC12: do I give this to you?
RC1: you just put it back in one of the boxes
20-00 PC12: oh right . okay

20-00 **M/61-75/ly/o**
RC1: || hello
PC13: || P (*surname*) . Dr Kerr . nine ten
RC1: lovely (.) and do you have your (2) yes . lovely . can I have
PC13: what do you want? . do you want this bit here
RC1: yes . I want . just the consent form {PC13: yeah . yeah} and you can have that . thank you very much
20-17 PC13: right . thank you

20-19 NCP

20-35 **M/16-25/ly/esm**
RC1: can I help || you?
PC14: || hi there . I've got another appointment with Dr Green this morning
RC1: and your name please?
PC14: G F
RC1: (.) lovely. can I have your consent form . please . and I'll give you that
20-46 as well . thank you very much

20-50 NCP

20-57 NCP

21-12 *RC2 checks what RC1 is doing on computer.*

22-05 **M/75+/lw/om**
RC2: morning
PC15: (.) I've to see the nurse at (.) ten past nine I think it is
RC2: (1) ten past nine . the nurse . and the name is?
PC15: B (*surname*)
RC2: that's fine . if you'd just like to have a seat dear=
PC15: =what do you want . to do with this then?
22-27 RC2: alright . it's just four questions to tick off . alright?

22-38 *Phone rings 6 times. RC1 arranges appointment.*

22-45 PC15: hm . I don't know . the answer to the first question
22-53 RC2: (.) oh . ha ha ha ha ha . ha ha ha . you're having us on . he he he

---

23-05 RC2: (*to HH*) at least somedy's got a sense of humour

23-28 *P15 hands in questionnaire*

23-44 *RC1, RC2 and RC3 discuss PC10's appointment schedule.*

24-11 **F/16-25/lm/ey. (Spanish speaker)**

RC2: right . er . you've signed (10) and I need the address (.) of the doctor
PC10: e:r . the thing was that I didn't . the doctor (.) I don't remember where=
RC2: =is that the name of the doctor?
PC10: no . it's (?only) the name of the place where I: . saw the doctor (.) it's in the health centre in (*name of place*) but I didn't (unclear word) the doctor because I just saw a doctor once and {RC2: mm . right} he prescribed the pill but then I just saw the nurse
RC2: right (.) that's fine . if . if you like to e:m
RC1: (1) let me see this . oh lovely . you're alright . she's already registered . if you just want to have a seat . please
RC2: no . no . right . if you just have a seat

RC1 and RC2 continue to discuss situation of PC10.

25-23 **F/41-60/lw/esm**

RC2: yes::
PC16: morning
RC2: || morning
PC16: || G (*surname*) . F G . I've got an appointment with Dr Williams
RC2: Dr?
PC16: Williams (1) nine twenty (*clears throat*)
RC2: that's fine . if you'd just like to have a seat thank you
25-38 PC16: thank you . do I give you this?

25-49 **M/61-75/ly/esm**

RC2: yes . may I help you?
PC17: can I . make an appointment please (.) for today
RC2: for today
PC17: if possible
RC2: (.) e::h (4) be eleven fifteen . open surgery
PC17: aha
RC2: that be alright? (.) could I ask your date of birth please
PC17: thirteen eight thirty-nine
RC2: (5) and your name <u>is</u>?
PC17: Y (*surname*) (.) W (*first name*)
RC2: 16 V Gardens? (5) fine . okay
PC17: (two words unclear)
RC2: aha . and can I hand you ?
PC17: I've got that
RC2: have you signed that?
PC17: aye
RC2: I'll take <u>that</u> one . there you are . and you've . fill in that
PC17: (4) dae I . do I take it with me?
RC2: aha . if you just have a seat thank you
PC17: I- . I've to come back
RC2: yes . well would you like to . fill in the . it's only four questions to fill in .
26-52 you've just to <u>tick</u> . all the answers . alright?

26-07 NCP

26-53 NCP

26-55 **F/26-40/ly/esm**

RC1: can I help you?
PC18: yeah . hi
RC1: thank you . that's lovely . and I'll give you this
PC18: eh . I've got an appointment at twenty past nine . with Dr Murray Browne
RC1: fine . right . and your name please?
PC18: E P
27-06 RC1: that's lovely . have a seat in the waiting-room please

---

RC1 and RC2 talk about appointments, 'the ten o'clocks and the elevens', the confusion regarding the registration of PC10 and the numbering of questionnaires.

29-30 **F/75+/lm/e3m**

PC21: Dr Glasgow . nine twenty
RC2: aha . would you like to go over and see the lady {PC21: yes} just at the ?? desk there

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29-37 **F/41-60/lm/esm**

PC19: em . A C . I've got an appointment with
RC2: I'm just . putting a:::
PC19: oh right
RC2: a patient's (3) yes . and you've . got an appointment?
PC19: yes . it's with . practice nurse Claire and Dr Nash together (1) quarter- . twenty past nine . A C
RC2: twenty past . practice nurse?
PC19: yes . practice nurse and Dr Cash
RC2: and your name is?
PC19: A C
RC2: that's fine . nine twenty
PC19: (?whispers 'thank you') now what do you want to give me for this? . a questionnaire or something? (4) thank you
30-19 RC2: right . thank you

30-24 **F/26-40/ly/esm**

RC1: hello:
PC20: got an appointment to see the health visitor . at nine fifteen
RC1: that's fine . give me your consent form and I'll give you this . and the baby's name?
PC20: H M
30-35 RC1: lovely . if you have a seat I'll let them know you're here

---

30-44 *RC1 calls health visitor to let her know that P20 has arrived with baby.*

30-50 *P comes out to RC1 after appointment with Dr Glasgow, says that nasal spray has been left off prescription. Phone starts ringing. RC1 says 'if you'll give me a moment I'll see if I can help'*

31-04 **F/75+/lm/e3m**

RC2: yes

PC21: nine twenty . Dr Glasgow
RC2: yes . I've booked you in . that's alright . would you like to mark that? . eh . yeah
PC21: what's this?
31-20 RC2: it's just four questions to tick off . alright?

31-23 *Phone rings nine times. RC2 takes message.*

32-47 **F/75+/lm/esm**
PC23: oh . that's mine
RC2: it's okay . have you had the questionnaire part? . right . I'll take that part . no no . this . this one . right . if you just give me both of them then (*consent form and information sheet*)
PC23: I haven't read the other one (*information sheet*)
RC2: oh . right
PC23: better read it
RC2: yeah . sure ( ) there y'are
PC23: now my name is S (*surname*) and I'm here to see Dr Murray Browne || at nine thirty
RC2: || Dr Murray Browne (.) that's fine
PC23: thank you
33-13 RC2: if you'd just like to have a seat thank you

34-33 **M/26-40/y/esm (Greek speaker)**
PC24: er . I've got an appointment at (.) I've got an appointment
RC1: and your name please?
PC24: K . K || (*spells name*)
RC1: || and do you know who it was with? (2) your first name?
PC24: K (*surname*)
RC1: your first name
PC24: er . G (*first name*)
RC1: lovely . it's for Dr Green yes?
PC24: okay . thank you
RC1: if you just fill that out and bring it back
PC24: mhm
34-53 RC1: thank you

35-07 *Phone. No rings. RC arranges .double appointment.* 37-06

RC2 tells RC1 that there's been a cancellation
RC1 is waiting to get incomplete prescription altered by catching Dr between consultations.

39-17 **F/61-75/lm/o**
RC2: good morning
PC25: good morning . it's for my mother Mrs C (*Chinese name*) || with Dr Glasgow
RC2: || that that's fine . if you'd just like to have a seat thank you
39-26 PC25: it's that way? (several words unclear)

RC1 and RC2 comment that PC26 is lovely and RC2 asks who he is coming to see.
RC1 explains computer use to RC2

40-54 **M/61-75/ly/esm**

RC1: can I help you?
PC26: Dr Williams . half past nine {RC1: lovely} M S
RC1: lovely
PC26: and I've to give you this
RC1: yes . thank you
PC26: thank you . can you tell me: if there's a special number for the surgery physiotherapist or will I get her through the main switchboard
RC1: for the physiotherapist?
PC26: yeah
RC1: you should just speak to the doctor when you go in . they should be able to tell you
PC26: okay . fine thanks

41-16 RC1: okay

41-47 **F/16-25/ly/ey**

RC2: morning
PC27: hi there . eh . I've got an appointment this morning to see Dr Lily . at nine thirty-five
RC2: (7) e:h (two words unclear) e:h (6) and the name is?
PC27: it's G S
RC2: (2) that's fine . if you'd just like to have a seat=

42-15 PC27: =okay . thank you

42-44 **F/26-40/lm/esm**

PC28: hi . em . N A to see em . Frances . the health visitor
RC1: right . I'll give you this . and you (.) have you signed that?
PC28: I have signed that . yes . do you need that one?
RC1: and you can have that one . and you said it was A (*surname*)
PC28: yes . it's N A

43-00 RC1: if you'll just have a seat in the (?upper) waiting room please

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43-08 *R1 calls health visitor to say that PC28 has arrived*

43-15 *Phone rings twice. RC2 arranges appointment.*

44-32 **M/61-75/lm/esm**

PC30: (*hears RC2 on phone saying 'your name is?'*) Finlay (*hears R2 saying '3 B Street is it?*') no . is that you? . hahaha (unclear words) . yes . I've relatives in B Street so . what's that . he he he . oh .
RC1: I'll give you this
PC30: thank you . and can I have a
RC1: not that . I don't want to give you that one . I want to give you this one
PC30: and a prescription for F (*surname*) plea:se
RC1: (.) for? (.) what was the surname || again
PC30: || F
RC1: (9) right (.) and when did you hand it in?
PC30: yesterday morning . about this time
RC1: right . it won't actually be ready until after two o'clock || toda:y
PC30: || oh . that's okay . that's . that's no problem . it's just that I was passing and I thought it might

RC1: it mi- . are you seeing the doctor this morning?
45-25 PC30: no-no . no no no

46-44 **M/75+/lw/om**
RC1: hello:
PC15: (1) what have I done with my stick?
RC1: (1) did you leave it in: . Gail's room?
PC15: I think I must have done
RC1: (*phones Gail*) did Mr B leave his stick in your room? (.) thank you . she's going to bring it out for you
PC15: could you: . get me a taxi
RC1: yes
PC15: it's at 51 . 51 South N Grove
Gail: there you go
RC1: ( ) and which one do you normally use?
PC15: er . 228 . 12 . 11
47-19 RC1: that's lovely . thank you

47-10 *Phone rings 4 times.*

48-12 RC1: (*to PC15 about taxi*) somebody's on the way

RC1 and RC3 talk about files and check them off.

50-50 *Phone rings once. RC1 arranges appointment.*

51-31 **F/16-25/y/o**
RC2: yes
PC29: there y'are . just to hand this in for my flatmate . (several words unclear)
RC2: (.) that's fine dear
PC29: thank you very much
51-45 RC2: right . thank you

52-16 **M/61-75/lw/esm**
RC1: yes
PC31: Mr L . nine forty-five with the nurse . please
RC1: lovely . and if you just go back and fill that in
52-25 PC31: okay

53-19 PC31: right . thank you
RC2: that's fine (3) and do you have an appointment?
PC31: pardon?
RC2: do you have an appointment?
PC31: yeah . I've said . I've . I've got another two after this . ha ha
RC2: oh . he's booked in . right . fine
PC31: I get two a week . ha ha ha
53-33 RC2: oh right

54-04 **M/75+/lm/esm**
RC2: yes
PC32: T (*surname*) . for Murray Browne
RC2: would you like to go over and see the lady there first?
54-11 PC32: oh I see . right

RC1 to RC2 that a patient has an open surgery appointment.
RC2 takes questionnaire from PC31.

55-34 NCP

55-36 **M/75+/lm/esm**

PC32: || er
RC2: || and that . nine forty . Dr Murray || Browne
PC32: || nine forty . Dr (?Murray Browne)
RC2: that's fine . if you'd just like to have a seat there . thank you (2) there's pens here for you if you || just
PC32: || aye . I think I've got a pen
55-46 RC2: okay

56-37 **F/16-25/lm/esm**

RC2: yes . may I help you?
PC33: em . I've got an appointment at nine forty with Dr Glasgow
RC2: Dr Glasgow (2) and your name is?
PC33: Z (surname)
RC2: sorry? . Z . aha (2) have you filled in the . have you filled (1) there we are . okay?
56-55 PC33: thank you

IA1 and RC2 make negative comments about piped music.

57-48 **M/75+/lm/esm**

RC2: || I'll just take
PC32: || it's the easiest questionnaire I've
RC2: (2) what's that?
PC32: (*louder*) it's the easiest questionnaire I've ever answ || ered
RC2: ||oh . we like to keep it simple
PC32: ha ha ha
58-00 RC2: (.) short and sweet

59-56 **M/26-40/ly/esm (Spanish name)**

RC2: okay . thank you
PC34: I've got an appointment with Dr Williams
RC2: Dr Williams . and the name is?
PC34: E (*surname*) (.) at nine forty
60-05 RC2: that's fine (.) okay

RC1 tells RC2 it's time for her (RC2's) tea break.
RC2 checks with RC1 that all patients are checked in.

61-11 . *RC1 arranges appointment. Phone rings 9 times during this call.*
62-44

63-51 NCP

64-53 **No details.**

PC35: (*clears throat*) I'd like to make an appointment to see Dr Nash please . I . I've signed my life away
RC1: you've signed your life away? . || we:ll!
PC35: || yes . I have . anything for a quiet life
RC1: and you're:e . wanting to make an appointment (.) or you have one?
PC35: no . I'd like to make one please . with Dr Nash
RC1: aha
PC35: I'd better get my diary out {RC1: aha} see how it works out (5) || not sure what I've done with it
RC1: || his first appointment wouldn't be till the sixth of November
PC35: I- . I thought it'd be something like that (3) thought I had my diary with me (2) oh well . it should be okay . sixth of November then
RC1: he's got five twenty five thirty or five forty
PC35: (3) I'll just make it five twenty . h-
RC1: and your surname?
PC35: er . M . M (*spells surname*)
RC1: (.) and your first name?
PC35: K
RC1: (3) || lovely
P35 || so that's the sixth of November
RC1: (1) at five twenty
PC35: at five twenty pippemmo (*p.m.)*
RC1: (.) with Dr Nash
PC35: okey dokes (.) right .seems to be awfully popular
RC1: yes he is . and he's on annual leave as well
PC35: pardon?
RC1: he's on annual leave in that time as well
66-14 PC35: goodness . what a crafty thing he is . haha . thanks a lot . bye just now

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66-14 **M/26-40/ly/esm**
RC1: hello . can I help you?
PC36: there's that form to hand in
RC1: yes . and I'll give you that one . and when do you have
PC36: || em
RC1: || do you have an appointment this morning?
PC36: at ten o'clock for Dr Glasgow
RC1: and your name please
PC36: G (*surname*)
66-30 RC1: lovely . if you just have a seat in the waiting room please

---

66-31 **F/41-60/lm/om**
RC1: hello:
PC37: good morning . I'm Mrs B to see the nurse at . ten (.) thank you
RC1: the nurse at ten o'clock hold on . lovely {PC37: thank you} if you'll just
66-41 have a seat in that direction please

67-08 **F/41-60/ly/ey**
RC1: just a moment (5) can I help you?
PC38: er yes . I've got ten o'c- . o'clock appointment
RC1: and your name please?
PC38: F (*surname*) . K F
RC1: (2) lovely (.) just have a seat in the waiting room and I'll give you that .
67-26 thank <u>you</u>

67-25 **M/41-60/ly/ey**

PC6: excuse me . I was just wondering if (?you could help me) . em (.) I asked for an appointment for . and they said there was a cancellation at nine o'clock 3 . was it for Murray (.) was it for Murray Browne || was it for doctor

RC1: || and your name please

PC6: Robin Pae . was it

RC1: (.) e:m . no . er (1) there was a nine forty this morning for Dr Nash but it's past so

PC6: oh no I g- . I just spoke to your colleague here . I came in . and they said there was a cancellation at nine o'clock

RC1: for today?

PC6: yeah

RC1: right . well it's been filled and it's

PC6: (.) || S-

RC1: || was it for you?

PC6: yes . S P . P (*spells surname*)

RC1: (2) right . lovely . if you'll just have a seat I'll let him . mm

PC6: w- . I mean . I spoke to your colleague here who said 'just take a seat . there's one at nine o'clock'

RC1: yes (2) em (1) she should be finished . if you'll give me a minute I'll speak to her

PC6: I just . I mean it was

68-22 RC1: if you'll have a seat I'll speak to them for you

68-13 **M/16-25/new patient**

RC4: can I help you?

PC39: (1) I have an appointment for this morning

RC4: (.) is this the open surgery?

PC39: with Dr Lily I think

RC4: Dr Lily

PC39: yeah

RC4: what was the name?

PC39: L F

RC4: (1) you're a wee bit late . || isn't that

PC39: || yeah

RC4: your appointment was nine forty . e:m . hopefully he'll still see you .if you're . sit for about five minutes and if he . doesn't call your name just come back to the desk

PC39: okay

RC4: alright?

PC39: em . I was wondering . what I should do . I was wondering what the: er . situation for students

RC4: (1) sorry?

PC39: what's the fee situation for students . || is it

RC4: || well . there is no charge to see the doctor

PC39: okay

RC4: mhm

PC39: okay . that's great . (?I'll discuss it with the doctor)

RC4: because you've already . er . filled in the forms and everything there || haven't you?

PC39: || yes . I filled in those . yeah . the registry form

RC4: (8) have you already filled in one of these?
PC39: (1) yep
RC4: and handed it to us? (1) that's . you've already filled this in
PC39: okay
RC4: is that correct?
PC39: I think so . yeah
RC4: and you gave it to us?
PC39: yeah
RC4: that's fine (1) so this bit here
PC39: (.) (?and I give the doctor the sample?)
RC4: that's right . you give that to the doctor . alright?
PC39: right . sure
RC4: (.) okay . just have a wee seat . as I say . if he doesn't call you in about ten minutes come back to the desk
PC39: okay
RC4: alright?
PC39: oh yeah and
RC4: (1) oh . that's yours
PC39: okay . thank you
HH: yeah . and could you fill that in as well
PC39: yeah . thank you
RC4: give you that . right . okay? ha ha
PC39: and can I get a biro?
69-58 RC4: would you like a . a pen? . alright . no problem . there you go

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69-12 **M/75+/lm/om**
RC1: can I help you sir?
PC40: an appointment . e:h . with Dr Nash at ten o'clock . P (*surname*)
RC1: (.) lovely {PC40: okay} if you'll just have a seat in the waiting room
PC40: this
RC1: lovely
PC40: yeah
RC1: I'll take that . and give you that (1) do you just want to have a seat please
69-28 PC40: yeah

69-29 NCP

69-42 **M/41-60/ly/ey**
PC41: (unclear)
RC1: lovely . and I'll give you that {PC41: yeah} and you can have this . thank
69-48 you

70-57 **M/41-60/ly/ey**
PC6: do you know what's happening?
RC1: em . yes . I've spoken to her . she's about to see you next
PC6: yes || was I- . was I in for the nine o'clock?
RC1: || if you just
yes . you were in for a nine o'clock slot
PC6: oh
RC1: I- . it just might've gotten overlooked . I'm sorry
PC6: I- . I- I- || I got that impression . yeah
RC1: || but she's going to see you . she is going to see you

PC6: aha . okay . thanks (6) er . er . did . excuse me
RC1: yes?
PC6: did it . do you know when she's goin- . how much longer it's going to be?
RC1: she's on her last patient . she's had him for a while .
‖ it should be quite quickly
71-28 PC6: ‖ yeah . so I was just . your colleague

71-37 **F/41-60/ly/varies**
RC1: can I help?
PC42: yeah . em . both I and my daughter have an appointment in open surgery (*gives names*)
RC1: yeah . lovely . if you just have a seat in the waiting room please
PC42: okay and . can I take a pen?
RC1: yeah . there's one there
71-51 PC42: right . thanks

73-51 **F/41-60/lm/esm**
RC1: can I help you?
PC43: got an appointment at ten o'clock with Dr Glasgow
RC1: and your name please?
PC43: C H
RC1: aha . okay . if you'll just have a seat in the waiting room please
PC43: (4) are you not going to give me a questionnaire thing?
RC1: oh . didn't realise you had the form . sorry
PC43: that's alright
74-13 RC1: (2) there you are . and I'll take that one . thank you

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74-39 NCP

Practice C, Disc 2: 10-00 a.m. Friday 17th October 2003

01-08 **M/75+/lm/e3m**

RC1: may I help you?
PC48: J G to see nurse at ten fifteen
RC1: (.) right . hold on a moment (4) lovely (9) just have a seat that way
PC48: thank you
RC1: and do you have your (.) er . no . did she give you a . something to sign (*consent form*)
PC48: yes
RC1: yes . that's what I need
PC48: you want that?
RC1: yes . I do . and I'll give you that (*questionnaire*)
PC48: right . thank you
01-33 RC1: thank you

RC1 and RC2 discuss mix-up over appointment for PC6.
RC5 comes round from filing area to discuss confusion over three patients with same name. RC1 suggests that she speak to RC4.
RC2 worries about computer error and RC1 announces departure for tea break.

03-33 **M/75+/lm/om**

PC40: hi there (.) I've to make an appointment with the nurse . for a blood test for two weeks || (unclear)
RC2: || two weeks
PC40: two weeks today I need . you know . or yesterday . it doesn't really matter . it's neither here nor there . approximately two weeks
RC2: (2) yes sir . that would be the Thursday the thirtieth of October
PC40: that's fine . yep
RC2: ri:ght . I can give you nine o'clock . or eight forty's the first appointment
PC40: || nothing later?
RC2: || the latest being . eh . nine twenty . or I can give you . eh (.) the afternoon at one thirty
PC40: one thirty would be more suitable
RC2: that be more suitable?
PC40: yep
RC2: right
PC40: great
RC2: can I ask your date of birth please
PC40: twentieth seven twenty eight
RC2: (3) and your name is?
PC40: P (*surname*) . R P
RC2: (3) 6 S terrace?
PC40: that's it
RC2: (7) that's fine . would you like a note || of that
PC40: || a wee crib . I would do . aye . memory gets a bit fickle . hh
RC2: (.) not at all
PC40: never admit it
RC2: hh hh hh
PC40: (*coughs*)

RC2: so that's Thursday the thirtieth of October with (14) and that's at one thirty
PC40: that's great (4) thanks very much
RC2: thank you . ba-bye
05-10 PC40: by:e

05-15 **F/75+/lw/ow**
RC2: there you are
PC49: thank you
RC2: right (.) kyu (1) your pe- . oh
PC49: (1) for the nurse . oh yes
RC2: (4) and you have an appointment with the nurse today
PC49: ten fifteen
RC2: (2) now I'll get the nurse up (3) eh . ten fifteen (.) is that Mrs M? . that's fine . if you'd just like to have a seat . thank you
05-46 PC49: thank you

10-07 **M/75+/lm/esm**
PC50: prescription list dear (.) for W F (*initial followed by surname*)
RC2: W F (*initial followed by surname*)
PC50: (*clears throat*)
RC2: (23) that's 25 W Road
PC50: that's right
RC2: there you are
PC50: thank you
RC2: now there's a pen there if you'd like just to tick the boxes . alright?
PC50: lovely . thanks
10-41 RC2: thank you

11-12 **No details. F**
PC51: see the nurse at ten thirty . M D
RC2: ten thirty (3) and the name is?
PC51: M D
RC2: (7) that's fine . if you'd just like to have a seat || thank you
11-30 PC51: || thanks

11-33 **M/26-40/ly/esm**
RC2: hello
P36: hello . can I make an appointment for next Friday for Dr Glasgow at . eh . ten o'clock
RC2: right . or (*clears throat*) (7) so is it to be ten o'clock || open surgery?
P36: || yes
RC2: right . next Friday (10) and could I ask your date of birth please
P36: it's . em: . fourteen nine fifty-two
RC2: (3) and your name is?
P36: E M
RC2: (4) that's fine . so that's ten o'clock . open surgery . next Friday
P36: thank you
12-24 RC2: kyu

12-48 **M/75+/lm/esm**
RC2: yes

PC50: I wonder if there's another one there . that's for paracetomols . I get one for . cholesterol
RC2: (3) did you request it?
PC50: I beg your pardon
RC2: did you request
PC50: yes
RC2: I'll have a look for you (13) I only have . e:h . the one . just one moment
PC50: it was on a . two o' them . two o' the prescriptions was on the one || sheet
RC2: ||on the one
PC50: aha
RC2: right
PC50: but previously I'd one like that . just with paracetomol
RC2: mhm
PC50: and I just got these . other ones || last week
RC2: || wh- . when did you hand your request in?
PC50: er . about Tuesday || or . I think it was
RC2: || about Tuesday
PC50: about Tuesday . aye
RC2: right (15) e:h (3) right . what I'm gonna do is this . I'm no gonna do this
PC50: ( ) Dr Williams wrote the prescription . on his machine
RC2: (.) oh . so Dr Williams did it
PC50: aha
RC2: when you were there
PC50: yes
RC2: and he's forgot . but this one's from Dr Glasgow . Dr Glasgow's signed this one
PC50: (.) o::h
RC2: (.) so do you mean your last prescription Dr Williams did it?
PC50: y- . aha . that's where I've been going to
RC2: mhm . mhm
PC50: and he gave us one || for
RC2: || aye . Dr Glasgow's signed that obviously . e:h
PC50: aha
RC2: for Dr Williams perhaps it was
PC50: ( ) cos he said I must take them every day . the other ones
RC2: ( ) and are you out of them now?
PC50: out of them . yes
RC2: right
PC50: just today
14-50 RC2: right . could you . could you just hang on one moment please

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14-51 NCP

15-18 NCP

R2 checks prescription details for P50

16-23 **M/75+/lm/esm**
RC2: right (4) yes . it's just paracetomol that's . up on (4) and what is it you normally get for your cholesterol?

PC50: eh (1) there was two pills . on for . water I think he said
RC2: aha . then
PC50: and one for . cholesterol . the way I remem || ber
RC2: || and is it the two items that you require?
PC50: yes
RC2: right ( ) well ( ) the receptionist that's actually doing prescriptions just now . er . won't be back for about another ten minutes or so
PC50: aha
RC2: so . if I put a request in for these two items
PC50: aha
RC2: would you be able to come back . later on today?
PC50: today?
RC2: yes . mi- . perhaps after two o'clock
PC50: er . I've got to do things
RC2: d- . do you need them today?
PC50: no
RC2: have you got enough to do you?
PC50: well . I- . I- I've took them the day
RC2: aha
PC50: so I . I need them for tomorrow
RC2: you need them for tomorrow
PC50: aha . I could come tomorrow
RC2: well . that's fine . the doors open at . eh . quarter to ten to half past eleven {PC50: hm . ye- . well} on a Saturday
PC50: I'll come and get them tomorrow
RC2: that's fine then .well we'll have the prescription ready for you {PC50: aha} now I'll get . I'll take your details first (17) and . eh . right . R X . that's fine (.) I'll give you that
PC50: aye || you |
RC2: || okay . and I'll just put 'will collect Saturday'
PC50: right (1) (several words unclear) I showed the doctor I'd the margarine . to lower cholesterol
RC2: oh . right
PC50: and I was out . then I had the prescription . and I tore up the: . marg- . and here it was the prescription I tore up
RC2: a::h . ri:ght
PC50: so I had to come in . he gave us . she gave us a new one out of there
RC2: (.) aha . || well we'll get this one ready || for you and that be alright for
PC50: || I'll come tomorrow
RC2: you to pick up tomorrow
PC50: thank <u>you</u>
RC2: okay . right . ba-bye
PC50: cheerio
18-36 RC2: ba-bye

19-09 **F/61-75/ly/esm**
RC2: now I'll jus:t be with you in a second . have you got an appointment?
PC52: (.) yes . I do (.) I think it must . it's for a flu injection
RC2: (.) and do you know who it's . is it with the nurse?
PC52: no . I think it's with the nurse . yes . I think it'll be with the nurse . my name is Dyer (*surname*) . D (*spells name*)
RC2: what time's your appointment?

PC52: ten thirty?
RC2: (5) mmm (1) must be with the nurse
PC52: is it not there?
RC2: (4) D . what's your first name?
PC52: A
RC2: (2) ten forty five
PC52: oh it's ten forty five
RC2: ye:s
PC52: oh . I should've looked at my diary before I came || out
RC2: || so do you wish to just
PC52: well . I'll just hang about . yes . I'll fill this in (.) there's a questionnaire I've got to fill in
RC2: (.) yes . have you . have you signed your: (*consent form*)
PC52: yes I have
RC2: right . I'll give you this and take . and I'll take those two from you (*consent form and information sheet*)
PC52: well I haven't read that (*information sheet*)
RC2: oh . alright . that's fine
PC52: can I have this pen? . or is it . I haven't got a pen with me
RC2: yes . aha . that's fine
20-09 PC52: or one of these'll do . right . thanks

20-15 NCP

21-54 **M/75+/lw/ow**
RC2: yes . who's
PC53: the . the nurse at ten . ten thirty
RC2: right . and your name is?
PC53: C (*surname*) . C (*repeats surname*)
RC2: (6) that's fine . alright . have you
PC53: (2) thank you
22-15 RC2: thank you

22-18 **M/61-75/ly/esm**
RC2: yes . may I help you?
PC54: yes . I'm here for my flu jag . I don't know if you want to . book me in or not
RC2: (3) e:h . and the name is?
PC54: M (*surname*) (1) M (*spells name*)
RC2: (*hums a little tune*) R (*first name*)?
PC54: yep
RC2: that's fine
PC54: ten thirty five
RC2: would you like to take your jacket off in readiness || for the nurse
PC54: || o:h . yes
RC2: || giving you
22-43 PC54: || right

22-47 NCP

23-00 **M/16-25/**
PC39: excuse me
RC2: yes

PC39: I received this number here . and I was wondering . is there a code to go with it? (.) it's not ringing properly
RC2: yes . well . if it's in Edinburgh you'll automatically do 0131 {PC39: oh} first before your number .
PC39: okay . alright
RC2: if you're using your mobile
PC39: what was that . 01
RC2: 31
PC39: 31 . okay then
RC2: and then your number . okay? . any number that you're phoning in Edinburgh . you've got to do the code first . if you're using your mobile
PC39: okay . thank you
22-30 RC2: alright? . by:e

23-39 **M/61-75/ly/esm**
PC54: could I have an appointment to see Dr Green some time
RC2: (7) and when would you like this appointment for?
PC54: any time you like
RC2: (3) e:h right (3) now the earliest would be Tuesday the twenty in the after↑noon
PC54: righto
RC2: that be alright?
PC54: yep
RC2: four o'clock?
PC54: Tuesday the twenty first . four o'clock . okay
RC2: could I ask your date of birth please
PC54: six one . twenty nine
RC2: (4) and your name is?
PC54: M (*surname*)
RC2: M . oh yes
PC54: thank you
RC2: that's fine . that's you booked in
PC54: Tuesday || twenty
RC2: || four o'clock . Tuesday the twenty first
PC54: thank you
24-29 RC2: thank you

RC6 asks RC2 about results for NCP.

25-47 **F/61-75/lw/esm**
RC2: yes . may I help you
PC55: e:h . yes I think that (.) I'll tell you what happened here . I don't know whether I'm . going daft or not but I was down at Dr Lingfield last week . and I was getting tablets . and he said 'I'll give you a month's supply' you see
RC2: mhm
PC55: and . 'take one a day' . and then . half way through it changed his mind (.) and he said 'ough . I'll give take three times a day' but when I went . today I thought 'my pills have gone down fast' but unfortunately he only gave me twenty eight which is a month if you're taking one but not if you're taking three . ha ha . you know what I mean
RC2: right || so

PC55: || so I wasn't sure if . I've enough . I think . to last over the weekend . just that one I've ticked at the top . but . I wasn't quite su-hh-re what
RC2: and he basically was giving you the prescription for . a month
PC55: || yes
RC2: || did you say?
PC55: he had written it down . he started off saying ' I'llgive you a month (.) one a day' . and then no . 'I'll make it fifty' . whatever it is . 'and take three a day' {RC2: mhm} but it was still just twenty . I didn't notice it until yesterday
RC2: right
PC55: it was just the twenty eight || so
RC2: || and you've been in and picked up the prescription for twenty eight?
PC55: well I got it . last week . I was at . at him last Friday
RC2: right
PC55: and I got my prescription . and I thought 'it's an awful wee packet' but of course it didn't click until I thought {RC2: mhm} 'oh . no wonder . that's not a month if I'm taking three' (laughing) if you know what I mean . I didn't want to shove it in and leave it and just get another week . I just don't {RC2: right . eh} quite know what the best thing is to do
RC2: (2) so that's only kinda doing you nine days
PC55: that's right
RC2: or so {PC55: aha} and you need enough to do you
PC55: well . he was gonna make it three a day which I've been taking
RC2: for: . a month?
PC55: aha
RC2: (.) right || so you basically
PC55: || and then I thought
RC2: you need . a prescription {PC55: yeah} to cover you for three weeks
PC55: that's right . and then I thought 'it doesnae mean that I'm taking . one only . I need a week'e suppl- . em . nine days' supply' . but I don't think he's meant it that way . I think it was || just he changed his mind
RC2: || but it is a month's supply?
PC55: that's what he definitely || said he was definitely gonna do
RC2: || said . right
PC55: and then I thought . cos I don't think he would change it to nine days . three times a day . if he just sorta cut thel: you know (2) just to . help my sore knee || which it's doing
RC2: || so do . do you have enough to do you
PC55: I think I'll manage over the weekend . yeah
RC2: over the weekend {PC55: aha} and . if I had this ready for you to pick up on Monday after two
PC55: that would be great=
RC2: =would that be alright?
PC55: yes . that's right
RC2: okay then
PC55: oh I've signed this . or something (*consent form*)
RC2: oh . right . this
PC55: what do I do with that?
RC2: there y'are . if you want to . fill that one in (*questionnaire*)
PC55: okay . thanks very much ( ) and I . I just . you know . I thought . they're going down fast
RC2: mhm . okay
PC55: but .eh . I mean . if I've got it wrong well he'll || but I don't think

RC2: || well . I'll get that checked first . just in case=
PC55: =that's in case he's just thought 'well . that amount does'
RC2: aha . we'll get that double checked for you || and it'll be ready for Monday afternoon
PC55: || and I'll look in on Monday
RC2: there's a pen there for you
PC55: oh right . thank you . I'll get
RC2: if you want to fill in the questionnaire
28-20 PC55: thank you very much

28-20 **F/No details**

RC1: hello=
PC51: =hiya . eh . can I make an appointment for M D (*male name*)for the nurse . he only got the flu . jag yesterday . he didnae get his other one . his eh . pneumonia . one
RC1: right
PC51: aha
RC1: so you're just needing to make another nurse's
PC51: well I th- . I think he was about the last patient and I think . she didnae think he should get it if he's only sixty-three . but he comes under the heart thing . so he . he
RC1: oh right
PC51: he got it . <u>done</u> . he's under (several words unclear) or something
RC1: can he come on Thursday the thirtieth at nine forty-five in the morning?
PC51: no . he has to make it late in the afternoon . have ye got a <u>late</u> one?
RC1: right
PC51: whatever day . it disnae matter (1) maybe a late one
RC1: I'll just look and see (9) right . let me see if the other sister has any (*phone starts to ring - 10 rings follow*) can he come at . four forty-five on the twenty-eighth?
PC51: that's fine (.) oh . that's his birthday!
RC1: what's the first name?
PC51: eh . M (.) four forty-five
RC1: G Road?
PC51: that's it
RC1: lovely . || and that's him in (.) at four forty-five
PC51: || on the twenty-eighth . that's lovely . okay . and I want to leave a prescription for him . can I just put it in the box? . do I . do I `use(*several words unclear because of telephone*)
RC1: there's this form there
PC51: that there . aye . and can I make an appointment with Dr Green for myself maybe
RC1: yes
PC51: some time next . maybe next Wednesday . or whatever else
RC1: (1) next week (2) he's got next Tuesday at . four-twenty . next Wednesday morning at nine fifteen or nine twenty-five
PC51: (?did you say a) four-twenty one? . (? and what other ones was it?)
RC1: Wednesday was just the morning at nine fifteen or nine twenty-five . or he's got the Thursday after two after three or first thing in the morning
PC51: give me the one at four twenty on . was it Tuesday? || that
RC1: || and your surname?
PC51: eh . M (*first name*) . M D . that's four . twenty on the . what date's that?

RC1: twenty-first
PC51: twenty-first . thanks ve:ry much
30-17 RC1: you're welcome

30-38 **M/26-40/ly/esm**
RC1: can I help you?
P46: yeah . em . I need to make an appointment with the nurse for some blood tests
RC1: right . and how quickly were you needing them?
P46: em s- . whenever . as soon as possible
RC1: right . we can give you eight fifty on . next Thursday
P46: (.) okay than
R1L: a:nd . your surname?
P46: H
RC1: (2) 1 C Road?
P46: yes
RC1: lovely . and that's you in for eight fifty on the twenty-third with sister Crosland
P46: eight fifty
RC1: twenty-third
P46: right
RC1: Thursday
P46: (1) thanks (1) okay
RC1: thank you
31-13 P46: (?you're welcome) . thank you very much

31-18 **F/No details**
PC51: aye . it's done . I think
RC1: (1) is it?
PC51: what happened with his prescription the last time? . his aspirin had nearly run out . and . it's like he's got . as if they've give him too many o' the: (.) oh . what's the word? . cholesterol . and he's . you know . he gets them three months at a time . and he's no got any . aspirin . only about six left
RC1: right . that would be something you'd have to take up with the doctor {PC51: aye} cos they're the ones who arrange the {PC51: aye} the amounts and things
PC51: aha . aha . aha . oh that's er . mebbe just a mistake . even if the chemist maybe made the mistake . I don't know
RC1: right=
P46: =but can I leave that for to get his aspirin?
RC1: yes . if you'll put it in the slot over there
P46: in there? || thanks very much
RC1: || yes . be ready after two on Monday
P46: that's okay . thanks a lot . bye bye
31-55 RC1: bye

HH and RC1 discuss the best times for recording: open surgeries at 11-15 and 14-00, when there's usually a big rush.

33-44 NCP

RC1: *(to NCP)* can I help?

36-54 *RC2 tells NCP that the nurse will fit him in after the next patient.*

37-48 *RC2 asks RC1 how to squeeze an emergency appointment into computer record and RC1 carefully explains how it is done.*

38-40 **F/61-75/ly/esm**

RC1: can I help you?

PC56: yes . can I have a repeat . prescription for C E N (*initials followed by name*) please . and there's your . thing

RC1: and I'll give you the other half of it in a moment (1) there you are

PC56: thanks . and I nee:d . a (3)

RC1: there you are

PC56: (4) o::h (7) if I put a prescription . a repeat prescription in today I don't get it till Tuesday . is that right?

RC1: Monday after‖ two

39-13 PC56: ‖ Monday

39-14 **F/26-40/lm/om**

RC1: hello:

PC57: hi there . I've got an appointment with Anna for em (1) jabs

RC1: right . and the . babies' names please

PC57: er . C and M B

RC1: right . if you'd like to have a seat . I'll let them know that you're here

39-28 PC57: kyu

39-38 *RC1 phones through to health visitor to say that P57 has arrived*

40-55 P*hone rings once.) RC2 answers but phone rings 14 more times. RC2 answers again and attempts to transfer caller to doctor's 'speaking time' line but finds out that it is already over.*

42-00 *RC1 leaves message on patient's answerphone asking him to call surgery.*

43-28 NCP

44-11 NCP

44-23 **F/14/fewm/esm**

RC1: hello:

PC58: hi (.) er . I'm J C . I've got a: . appointment with Dr Williams . for quarter past eleven I think

RC1: quarter past eleven . oh yes . lovely (2) let me see (.) lovely (.) and do you have the:? (*consent form*)

PC58: yeah

RC1: lovely . and I'll give you that . if you just want to have a seat in the

44-43 waiting-room please

44-50 *RC2 asks why calls are coming to desk, lifts phone and finds it's a caller on hold for another line.*

45-41 **F/75+/lm/e3m**

RC1: hello:

P21: (1) can I make an appointment to see Dr Glasgow (.) about (1) twelfth thirteenth November
RC1: yes . hold on (3) just a minute . I'm looking for the (7) right . she's got the twelfth at half past nine or nine forty (.) or she's got the thirteenth after four o'clock and after five
P21: (.) doesn't matter
RC1: would you prefer one for morning or afternoon?
P21: well . the twelfth
RC1: the twelfth at nine nine thirty or nine forty?
P21: nine thirty
RC1: and your surname?
P21: (2) the name is . eh (.) J C
RC1: (5) G Gardens? (.) lovely
P21: (1) nine thirty with Dr Glasgow
RC1: on the twefth
P21: hm:?
RC1: on the twelfth
P21: (.) on the twelfth at nine thirty
RC1: mhm
P21: thank you very much
46-48 RC1: bye bye

RC2 asks RC1 who has the initials EN. RC1 explains that it's RC5.

Brief discussion between IA1, HH and RC2 about advanced age of some patients.

Flowers handed in for Dr Glasgow from grateful patient.

50-01 *Phone rings twice. RC2 puts caller on hold and then arranges appointment.*

51-30 *Phone rings first 11 times then stops, then again once. RC1 arranges appointment.*

52-40. *Phone rings 10 times.*

53-18 *Phone rings twice. RC1 arranges appointment.*

54-55 *Woman drops something off.*

55-16 *Phone rings once. RC1 arranges appointment.*

55-52 *Phone rings twice. RC2 arranges appointment.*

56-29 NCP

56-53 NCP

57-13 **F/26-40/ly/esm**
RC1: hello . can I help you?
PC59: thanks
RC1: (.) I'll take this and give you that . and do you have an appointment this morning?

PC59: no: . I was just putting a prescription in . thanks
57-23 RC1: oh right

59-15 **M/26-40/lm/esm (Arabic name)**
RC2: yes?
PC60: (2) oh sorry . right . er . prescription as well . A Y
RC2: and the name is?
PC60: A Y (*spells name*)
RC2: (5) and the address is?
PC60: 63 N Grove
RC2: there y'are
PC60: thanks
59-38 RC2: thank you

59-57 **F/61-75/lm/om**
PC61: er . Mrs P for the nurse
RC2: er . would you . have you seen the lady? . would you like to go over to the lady (*IA1*) {PC61: yes . fine} first please
60-05 PC61: yes dear

60-16 NCP

61-24 RC1: hello!
PC61: hello: . got the right date today I hope
RC1: Mrs (.) P (2) (*patient moves away*) oh god . please tell me she's got the right day (.) och . phew (*goes into waiting area to patient*) can I get you to fill this out (*questionnaire*). it goes along with the paper (*consent form*) which you
62-00 filled out when you came in . and then just put it in the box

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RC1 explains to RC2 that she had the wrong name for P61.

62-37 **M/16-25/ly/esm (Indian name)**
PC63: hello (2) okay . I'm here to see . ele- eleven fifteen open . surgery is it?
RC1: mhm
PC63: do I just take a seat do I? . or do i
RC1: your name?
PC63: S P
RC1: (2) lovely
PC63: yeah
RC1: just have a seat
62-52 PC63: okay

RC1 asks RC2 if a certain name is not on the computer.

63-00 PC63: can I borrow a pen off you . please
63-03 RC1: there should be one on the desk there

63-25 **M/16-25/lm/om**
RC2: yes {PC64: hiya} may I help you?
PC64: yeah . I've got an appointment for the open surgery at . er . quarter past eleven
RC2: and the name is?
PC64: M (*surname*)

RC2: right . have you been and seen the
PC64: I've not
RC2: the lady
PC64: sorry
63-35 P64 oh right

63-27 **F/41-60/ly/esm**
RC1: can I help you?
PC62: (.) yeah P (*first name*) (surname unclear) for eleven fifteen surgery
RC1: okay . now I have to give you that
PC62: and I give you this one
RC1: yeah . lovely . that's fine . if you just want to have a seat
63-35 PC62: okay (one word unclear)

64-12 **M/16-25/o/o**
RC1: hello:
PC65: I've got an appointment for . quarter past eleven
RC1: and your name please?
PC65: G R
RC1: er . yes . I know you're on this list somewhere . there . lovely . and I'll give you this
64-28 PC65: thank you

64-29 **M/16-25/lm/om**
RC2: may I?
PC64: cheers
RC2: and your name was
PC64: D
64-36 RC2: that's fine . if you just (remainder unclear)

64-49 NCP

65-37 **M/61-75/lm/ey**
RC2: there y'are
RC1: she's got it ready for you
PC66: can I make an appointment for a flu thing (.) || please
RC2: || for a flu vaccination?
PC66: mm
RC2: yes
PC66: (*to RC1*) are you okay dear? (1) (?oh dear) . she's gone away
RC2: (2) right . so (20) right . e::h . a::w (*hums a few notes*) (19) right
RC1: (*to PC66*) just fold it up and stick it in the box (*questionnaire*). please (12) thank you
RC2: (4) r:ight . that's two thirty (2) right . I could give you three thirty-fi:ve on Wednesday the fifth of November
PC66: yeah
RC2: that be alright for you?
PC66: yeah
RC2: (.) and could I ask your date of birth please?
PC66: twenty ten thirty-three (.) can I just pinch one of these things?=
RC2: =yes
PC66: to . take a note of
RC2: yes . certainly

PC66: thanks (.) sorry . could you say that again?
RC2: and your name is?
PC66: L (*surname*)
RC2: D (*first name*) || is it? . nineteen W Path?
PC66: || yes
RC2: (*at dictation speed*) that's three thirty-five on Wednesday . the fifth of November
PC66: (.) okay
RC2: is that it?
PC66: thanks very much
67-46 RC2: right . thank you

RC2 says 'right . that's the fifth all fully booked'

68-12 *that* *PC61 returns to desk to check that she has an appointment. RC1 confirms she has one with the nurse.*

68-26 NCP

68-35 NCP

68-39 **F/61-75/lm/om**

RC2: || there y'are
PC67: || hi . I'm (several words unclear) . I had a letter from Dr Murray Browne this morning to say the bowel test I had handed in (.) they hadn't received it and that's nearly four weeks ago
RC2: mhm
PC67: and I phoned and told her secretary that it was returned {RC2: mhm} immediately . and I just wondered if Dr Murray Browne was available (.) to see what's gonna happen now because I'm going on holiday next week
RC2: well . I'll tell you . e:m=
PC67: =you see . I couldn't phone her at her speaking time because I do a wee job || (?could)
RC2: || aye . they're due to start surgery
PC67: aye
RC2: em . would you be able to phone in on Monday's speaking || time
PC67: || no . I'm away on holiday || as I was saying
RC2: || oh . you're away on Monday . oh . I thought you said next week meaning that you were still here
PC67: I go on Monday . no . I go on Monday . on Monday to Friday
RC2: r:ight . em
PC67: probably her . her secretary's maybe told her . obviously she would (.) but I did wonder if I have to do it hhh all over again {RC2: right} it's a horrible one
RC2: e:h . well I would imagine if that was the case they would get in touch with you
PC67: well . she has been phoning and I've not been in when she's been phoning
RC2: ph- like Dr Murray Browne has
PC67: yes . I don't have an answering machine {RC2: r:} (several words unclear)
RC2: what's your name?
PC67: Mrs S G
RC2: (8) and what's your date of birth?

PC67: twenty-nine three thirty-two
RC2: (.) and Dr Murray Browne's been trying to contact you || you say
PC67: || she said that in her letter . yeah . cos she was on holiday just when I
RC2: right . if you want to have a wee seat . I'll see if I can get in touch with Dr Glasgow to . eh . with Dr Murray Browne {PC67: Murray Browne} to let her know that you're in . and you wanted to know the result of
PC67: no
RC2: no?
PC67: no . I . sh- . they (*lowers voice*) you have lost my bowel test . that I handed in here
RC2: oh . (*lowered voice*) right . right . aha
PC67: (.) a:nd . I phoned her secretary to tell her
RC2: mhm
PC67: but just when I'm hhh passing . I wondered if
RC2: mhm
PC67: I had to do it all over again
RC2: right
PC67: you know . you've got to do it in a scale of five days so I'm not able to do it
RC2: no . no .right . if you just have a seat=
PC67: =have a seat . okay dear
RC2: I'll see what I can do
70-44 PC67: right

70-42 NCP

Practice C, Disc 3, Track 1: 2-00 p.m. Friday 17th October 2003

00-52 **F/16-25/o/esm**

RC3: hello
PC69: hi there . em . I was wondering if it would be possible to register with yourselves
RC3: where do you live?
PC69: em . W Park Road
RC3: yeah . how long are you going to be at that address?
PC69: e:m . for the foreseeable future
RC3: (9) so you fill in the first two
PC69: okay
RC3: that's for your information . that's for a urine sample . which you bring when you have your (.) new patient health check
PC69: okay
RC3: do you want to make a check now? . or
PC69: e:m . yes I will . that be great
RC3: okay
(*A short passage of unclear talk and an exchange between RC3 and another receptionist followed by a 35 second break*)
RC3: em . you wanted a: . new patient health check . let's see if we can get this for you (2) can you come at any time?
PC69: em . yes . pretty much
RC3: that's lovely (1) so I could put you in . on Monday the twenty seventh at half past eleven?
PC69: (1) em (.) yep . I'm just meant to be starting a new job and I don't have the . new start date yet (.) || em
RC3: || well . do you want to phone in?
PC69: it's just a case . yep . yep . cos . once I've got that start date it be easier || for me to phone in
RC3: || okay . phone in . but if you could do it before you're ill . we'd like to have that back
PC69: yep . hh hh . I know
RC3: okay . bring . er . if you bring all those things with you when you
PC69: || bring everything when I come
RC3: || when you've made the appointment with the nurse . it doesn't take long . it's only ten minutes
PC69: yep . great . okay then . thank you
RC3: thanks
PC69: bye

02-49 RC3: bye

03-04 **M/41-60/lm/om**

(*RC3 and PC70 exchange consent form and questionnaire*)
RC3: that's for you . and you have an appointment . do you?
PC70: no . I want to make one
RC3: you want to make one (.) with?
PC70: e:m . Dr Green
RC3: Dr Green . just a sec . let me have a look . see what he's got (5) W:ednesday the twenty-second at . quarter past nine (.) is that too early?
PC70: no . okay
RC3: is that alright?
PC70: yeah

RC3: okay . what's your date of birth please?
PC70: eh . eighteen . O seven . fifty
RC3: (6) Mr J C
PC70: yeah
RC3: (4) do you want me to write that down for you?
PC70: yeah . okay . please
RC3: (12) there y'are
04-03 PC70: okay . thanks

04-45 *PC70 hands in questionnaire and is thanked by RC3.*

Practice C, Disc 3, Track 2

RC3 comments that surgery is quiet.

00-40 *Phone. RC3 arranges appointment.*

03-54 **F/61-75/lw/om**

RC3: hello
PC71: hello:
RC3: (5) that's what you need (.) for that (*questionnaire for consent form*) . have you got an appointment? . or
PC71: no . I . it's a pr- prescription {RC3: prescription?} I'm picking up . Mrs W (3) do you want me to tick this (*questionnaire*)?
RC3: (1) for . Mrs D W is it?
PC71: that's correct . yes
RC3: there you are
04-21 PC71: thank you very much indeed

04-31 **F/41-60/ly/ey**

RC3: right . have you got an appointment?
PC72: no . I'd like to make an appointment . I'm not sure whether it's one or two . em . I want to make . make one for myself {RC3: mm} for something fairly minor . and em . . I've got a twelve-year-old daughter {RC3: mhm} and . em . when I- . I had her . when she was being fitted for shoes {RC3: mhm} I was advised by the man who fitted her to bring her along to the doctor and
RC3: || have a look at her feet
PC72: || just get her feet checked {RC3: mhm} because he thought that she . had something that would need . physio {RC3: aha} obviously he said to check
RC3: okay
PC72: || so I don't know whether
RC3: || is it any particular doctor?
PC72: em . Dr Glasgow if I can || I mean there's no urgency . so
RC3: || Dr Glas- . for both of you . do you want to have it sort of combined?
PC72: ye:s . aha . I'm . I'm not really sure whether . whether we'd need one appointment or two
RC3: give you two
PC72: right . okay . that's fine
RC3: (5) I can offer you two in the afternoon of Tuesday the twenty-eighth
PC72: (1) that sounds fine . oh . em . how late?
RC3: three o'clock {PC72: no} up to three-thirty
PC72: no . sorry . I can't make that || em
RC3: || and there's one the next day . Wednesday the twenty-ninth
PC72: aha . what time would that be?
RC3: two ten . two thirty . or three ten
PC72: em . three ten {RC3: three ten?} and I'll collect her from school . yes
RC3: I'll put your daughter at three thirty then
P72 yes . that's fine
RC3: so . what was your date of birth?
PC72: fifteen eight fifty
RC3: it's Mrs M A?
PC72: that's right . yes

RC3: (8) and then three: twenty . I'll put your daughter in . what was her date of birth?
PC72: six two ninety one
RC3: (8) six . two . nine- . ||I'm not getting anybody up (1) what's her
PC72: || oh
RC3: name?
PC72: sorry . five two ninety-one (several words unclear) . I actually wrote it down cos I knew I was going to get mixed up . ha ha
RC3: and that's
PC72: E
RC3: E
PC72: yes
RC3: (4) okay . that's then down
PC72: that's fine . thanks very much (2) it's names and . dates
RC3: dates . oh I'm hopeless with numbers
PC72: (1) but it's names now . I just find that
RC3: age group
PC72: yes hh hh hh (.) thanks very much . oh . did I have something to fill in? . did I have this?
RC3: yes . that's a pen (.) fill it in up here if you like

07-06 PC72: (several unclear words) get my specs out

07-18 **F/41-60/lm/om**

PC73: er . it's D- (*diminutive form of first name*) . Douglas (*full first name*) C (*surname*) to see the nurse (.) two o'clock . and one of these please

07-41 RC3: (17) there you are

07-52 **F/41-60/ly/ey**

PC72: I'm not sure about that . whether it's
RC3: (.) you don't have to do it
PC72: ye:s . I'm not sure how often . I don't
RC3: you don't . oh I see . yes
P72 ye:s . aha
RC3: (3) || I don't think it's . the important thing
HH: || it's just to get the general
PC72: it doesn't matter that much . yes . it's either every year or
HH: if you were coming every . every few days . that would mean . everybody knew you better

08-15 PC72: right . ha ha . okay . thanks very much

10-21 NCP

HH asks RC3 how she knows when to replace front desk stationery.

15-56 *Phone rings twice. RC3 arranges appointment.*

16-58 *RC1 returns to desk and discusses ongoing work with RC3.*

17-50 **F/16-25/o/o**

RC1: can I help you?
PC74: yeah . em . I've got an appointment at twenty past two but I've got to . em . register here cos I was in . away . I was away . at uni . so I've moved back here

RC1: and you're?
PC74: M R
RC1: (5) oh lovely . it's not till four twenty . lovely . I'll give you that . and you can fill that out . and then I'll give you . I'll . I'll keep that {PC74: mhm} and then I'll give you all the paperwork to fill in . for registering . hold on (2) okay (3) and do you stay here now?
PC74: yep
RC1: (7) okay . you'll need to . to . fill this out quickly for us . and give it back . so we can put it on the computer (*inbreath*)
PC74: || mhm
RC1: || em . your name . your address . sign and date to there . and all the other information you can give us . if you don't know it leave it blank
PC74: okay
RC1: that's a new patient welcome pack . there's a list of telephone numbers . doctors . how we do prescriptions open surgeries and everything else
PC74: mhm
RC1: and this is your new patient questionnaire which you'll need to fill out before you see the doctor today . it just gives the doctor a general overview of your: . health
PC74: right . okay
RC1: I'll need you to fill that one out first and then give it back to us . and then fill that one out when you're waiting on the doctor
PC74: okay . no problem
RC1: and this as well if you can . if not . bring it back the next time you see the doctor
PC74: okay
RC1: || okay?
PC74: || okay . can I take one of these pens?
RC1: yes you can . and I'll . get a clipboard for you to write on
PC74: it's okay I'll
RC1: there's magazines and things
PC74: I'll (?use the) stuff in there
19-12 RC1: thanks

19-20 *RC1 tells RC3 she can go for break.*

HH asks RC1, an American, about her husband whom she met through the Internet.

19-54 **F/61-75/lm/om**
PC75: right . I've to give you that || okay?
RC1: || thank you very much . and you can have this one back
PC75: yes . er . and it's to see the . oh sorry . the nurse I've to see and I've to apologise . for being late
RC1: o:h . it's fine
PC75: it's terrible . I didn't even know what time it is . I couldn't see (*gasps*) oh dear . Mrs D G
RC1: what time?
PC75: it was quarter to two . hope I haven't kept her waiting . has she got || some
RC1: || if you just want to have a seat . em . there . I'll need to give you (.) somebody's . taken them . hold on || a minute

PC75: || aye . as long as I complete this . (*louder*) I've got a biro
RC1: no . if I give you one of these . if you take off your jacket as well . it just makes it easier when she gives you the flu
20-27 PC75: oh yes . aha . thank you

20-28 **M/26-40/lm/esm**
RC1: can I help you?
PC76: er . I've got an appointment at two o'clock (.) K
RC1: (.) K T . hold on a minute (1) K: (*first name*) . that's lovely . if you'll just have a seat in the waiting-room please . when you've finished with that . (*to HH*) did you put the number on it? . (2) sorry . I was speaking
PC76: it's okay
RC1: (1) I'll give you this . you can have that one (*questionnaire*)
PC76: okay . thank you
20-55 RC1: and I'll take this one

21-03 NCP

22-52 NCP

The back of RC4's chair slips dramatically and RC1 explains that it has already been repaired once by Dr Green, the practice handyman.

27-24 **F/26-40/y/daily**
RC1: there you are . || I'll give you that . and take that (*questionnaire and consent form*)
PC77: ||hi thank you
RC1: let's see (3) thank you
PC77: and em . can I pick up the (.) ones for B and for M (*areas of city*) for Lloyds please
RC1: yes
PC77: (4) do I put it in there . this . this . questionnaire?
RC1: there you are (6) and there's that one as well . any ones you're missing . just let me know
27-58 PC77: I will (.) thank you

PC77, who is collecting prescriptions for pharmacy, tells RC1 that there are three missing. RC1 tracks down two of them and finds the third shortly after PC77 leaves.

30-00 NCP

30-28 **F/41-60/o/o**
PC78: hello . em . I've got an appointment with . er . I can't quite remember who . what was his name? . em
RC3: I'll tell you in a minute . what was your name please?
PC78: er . er . H (*surname*) . and er . er . er . J . or C (*first names*) . depending what you've got . H . at er . a quarter past two
RC3: quarter past two . er . was it with the nurse? . or
PC78: no . no
RC3: J H

PC78: that's it
30-49 RC3: that's lovel:y . have a seat thank you

RC1 tells couple from pharmacy she's already discovered that prescriptions are not in alphabetical order.

HH asks how often pharmacy's send someone to collect repeats. RC3 replies that it can be every day or twice a week, that some are sent out and urgent ones faxed.

RC1 comments that things are always in motion at practice. Next thing will be preparation for quality practice inspection.

36-04 NCP

RC1 tells HH why she made sure that the learning difficulty patient didn't take part in the study.

40-50 **F/16-25/o/o**
RC3: hello
PC74: hi . (?I'm sorry) . er . my mum had a prescription here . that she's asked me to pick up for her
RC3: what's her name?
PC74: er . D R
41-11 RC3: (12) there y'are

41-20 **M/61-75/lw/om**
RC1: can I help you? (*phone rings*) that would be my phone in my bag
RC3: hello: . are you here || again?
PC79: || I'm going to study the receptionists
RC3: (2) oh you've done that . all that
PC79: I'm studying you=
RC1: || you're studying us
RC3: || but you do that every time you come in
PC79: (.) never (.) || hh can I have
RC3: || well perhaps we study you
PC79: can I have a prescription please?
RC3: for?
PC79: (2) whisky!
RC1: for whisky? . ha || ha ha
PC79: || ha ha ha . C (*surname*)
RC3: your first name is?
PC79: R
RC3: there y'are
PC79: kyu (2) hurray . it's the right one . ha ha ha (.) so what do I do now?
RC3: you give me that (*consent form*)
PC79: ye:s (2) and I make horrible comments about the reception
RC3: that's right (.) and then we all get sacked again
PC79: (3) are you male or female? . you never know (.) is it crosses or ticks? . ticks (.) do you want me to get out of the road in case other folk come?
RC3: uh uh

PC79: what age group do you belong? . oh I belong to about the teenagers but I <u>am</u> (.) that (*sigh*) when did you (*long sighs*) well it used to be once a week (2) but it's now between there (2) this place . is that all?
RC3: that's all . there's no room for || any nasty comments
PC79: || there's nothing to say what do you think of the receptionists
RC3: well . you can always <u>add</u> that
PC79: can I? ( ) I can't spell the word
RC3: but we know it'll be nice anyway
PC79: ha || ha ha . what do I do with this? (*questionnaire*)
RC3: || ha ha ha
I think you put it in there . but you have to fold it up first
PC79: can I give you that?
43-01 RC3: thanks

43-10 **F/61-75/lm/esm**
RC3: || hello
PC80: || can I hand in these (*flowers*) for Dr Stead please
RC3: Dr Stead?
PC80: yes please
RC3: thank you very much
PC80: and I've this form for this questionnaire . if I can do it quickly . I haven't got an appointment . I've just got to hand these in
43-27 RC3: (6) it's . very easy

RC1 asks RC3 if she's spoken to colleague.

Flower delivery.

IA and RC1 chat about latter's home in the US. where R1's home is -

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48-17 **F/41-60/ly/ey**
PC81: hi there
RC1: there you are (1) kyu
PC81: I've got an appointment with the travel nurse at two thirty (.) A M's the name
RC1: (5) lovely . if you'll just have a seat that way please
48-33 PC81: lovely . thanks a lot

RC1 explains to HH about travel vaccination forms and their cost.

50-26 *Phone. RC1 arranges appointment.*

51-06 NCP

51-36 NCP

52-50 **M/41-60/o/o**
RC1: I'll give you this first
PC82: yes and . er . want to pick up a repeat prescription please
RC1: and the name please?
PC82: er . it's my son . P K
RC1: (6) there you are

53-05 PC82: thank you:

52-55 **F/16-25/y/om**

RC3: who's next please
PC83: hiya (.) just give you this
RC3: thank you (.) that's fine (5) that's the other one . have you got an appointment this afternoon?
PC83: no . I've em . just come to collect . a prescription
RC3: for?
PC83: K H (1) 28 P View?
53-27 RC3: thank you (.) right

P missing

53-12 **F/16-25/o/o**

PC84: hi . I've got an appointment at half past two
RC1: and your name please
PC84: er . K B
RC1: (2) lovely (1) em . we have that . and I'll give you that (9) can I help you? . oh . sorry
PC84: there's this . and also I need to . em . pick up some . em . (.) sample
RC3: ‖ what was it?
PC84: ‖ for my husband . er
RC1: was it left for him?
PC84: S G . yeah . I think it's
RC1: (.) yes
PC84: (1) that's the thing complete
PC83: do I just fill this in now do I?
RC1: yeah (.) it shouldn't take you long . hh
PC84: (3) shall I just go ahead and take a seat?
53-58 RC1: yes . please (.) thank you

RC6 explains that the daughter of Dr Williams, who is out, will be coming in to collect a key.

When IA1 remarks that a patient has gone off with a pen RC1 says 'we get a lot of free ones from reps anyway'.

RC1 tells RC3 that the stickers that she's looking for are in the storeroom.

56-54 **F/16-25/o/o**

RC1: can I help you?
PC86: hi . could I pick up: a: . prescription please
RC1: yes . and the <u>name</u>?
PC86: it's . G
RC1: (1) and the first name?
PC86: it's . J . or G
RC1: (1) G . (?right) (2) and when did you hand it in?
PC86: it wasn't actually me . it's my mum's . but I think it was . two days ago
RC1: (.) right . (several words unclear) (2) what was your first name?
PC86: K- (*breaks off part way through first name*) . er . my name's K
RC1: (3) mhm . while I'm having a look {PC86: okay . yes} could you fill in that please
57-27

57-48 PC86: I'm just waiting

57-50 **F/41-60/o/o**

PC78: hello . em . could I make another appointment please {RC3: yes} with . er . Dr Lily
RC3: Dr Lily . yes . one momet
PC78: em (3) is the s- . second of November any good?
RC3: I'll have a look for you
PC78: a:nd . he said preferably in the morning . em
RC3: second is . a Sunday
PC78: oh right . er . third then . I suppose . (?what)
RC3: in the morning or in the afternoon?
PC78: er . morning if possible
RC3: eight forty to nine forty . when would you like to come?
PC78: erm (.) I think nine forty . ha ha
RC3: nine forty . right . your date of birth please
PC78: er . thirteen five forty-six
RC3: (6) Mrs J H
PC78: yes
RC3: (2) shall I write it down for you?
PC78: thanks
RC3: (9) there y'are
PC78: (1) do they do this in English?
RC3: (.) I don't know
PC78: (1) yes . it's just . it's my parents . it's not || it's my father . my father's ninety-six
RC3: || well . they could . they could ask
PC78: could I take the leaflet just
RC3: of course you can
PC78: I'll ask his doctor . okay . thank you very much

59-12 RC3: bye

58-46 **F/16-25/o/o**

RC1: there's not been anything handed in for you
PC86: okay . well . it wasn't me || I'm not sure what to
RC1: || you could fill up one of those but there's not actually been anything handed in for you
PC86: okay . but she definitely handed it in two days ago
RC1: did she? . well there's not been anything like this (.) not handed in (*phone has rung seven times*) good afternoon . appointments . will you hold please . em (1) your date of birth (.) || just to make sure
PC86: || mine or my mum's? . cos it wasn't for me . it was for my mum
RC1: oh . and her surname was G . and what was her first name?
PC86: her first name is J . or G
RC1: (3) right . let me see . if there was anything done for her it was done today (.) right . hold on a minute
RC3: (56) are you being seen to?
PC86: I'm just waiting . yeah
(*Four minutes pass. Phone beeps occasionally as still on hold.*)
RC1: and it wouldn't have been posted out to the chemist?

PC86: I don't think so . no
RC1: (.) right . well we'll do (?something) . if you want to have a seat . we'll see if we can find it for her . or get another one done for you . okay?
64-50 PC86: okay

64-55 **F/41-60/lm/esm**
RC3: who's next?
PC87: prescription for M (*surname*)
RC3: M?
PC87: yeah . 12 K Place
RC3: (.) excuse me
PC87: (31) just thinking I've got one of these
65-47 RC3: (2) that's the next part to complete . that's it there

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65-01 NCP

65-39 **F/61-75/lw/esm**
RC1: can I help you? (.) lovely . and that one
PC88: I've an appointment with Dr Lily
RC1: (.) and your name please?
PC88: C (*surname*)
RC1: (6) what was the surname again?
PC88: C- (*breaks off after first syllable*) . C (1) E C
65-59 RC1: lovely . and just . have a seat in the waiting room please

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Receptionists talk about missing prescription and getting flowers which have been delivered to recipient, who is at home.

67-00 **F/26-40/lm/esm**
RC3: hello
PC89: hi . I'm early actually . for an appointment with . doctor
RC3: our locum is it? . what was your name?
PC89: it's . B B
RC3: it's Dr . Ness
PC89: it's three o'clock . the appointment
RC3: that's lovely (1) || and you want to swap this over (*consent form and questionnaire*)
PC89: || and I've got one of these . yes
RC3: okay (2) that's a very small questionnaire
PC89: (2) okay . thank you
67-25 RC3: thank you

PC89 checks with RC3 on how to fill in questionnaire.

68-20 **M/61-75/lm/esm**
RC3: hello
PC90: hello
RC3: || just give you one in return
PC90: || I'm here for my flu jab
RC3: for your flu jab
PC90: at . er
RC3: right
PC90: two fifty

RC3: (2) what was your name please?
PC90: er . Mr H . H (*spells surname*)
RC3: (2) what time was your appointment?
PC90: (.) two fifty
RC3: two: fifty:: (1) yes . that's with (4) do you know who your appointment was with?
PC90: (.) I didn't say . er
RC3: ( ) H (*spells surname*)
PC90: yes
RC3: (4) B H was it?
PC90: that's me
RC3: Friday two fifty . that's lovely . and that's for your information about the flu

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APPENDIX 2

Information from interviews with receptionists

Practice A

Receptionist (age)	Length of service Previous work	Training	Favourite aspect of job	Least favourite aspect of job
RA1 **(40s)**	2 years receptionist in family plumbing business	in-house	working at the front desk 'I'm a people person'	awkward patients
RA2 **(50s)**	13 years, as reception manager secretary	in-house refresher course practice exchange	when patients come back and say thanks	staying detached when dealing with irate patients
RA3 **(40s)**	10 years, 3 as receptionist secretary	in house	working with public, specially the pleasant majority	patients for whom nothing is good enough chasing up non-attenders
RA4 **(30s)**	10 years clinical administration. Inland revenue	in-house refresher courses	interaction with public	chasing up non-attenders for clinics lack of privacy at desk
RA5 **(40s)**	1year 8 months filing cashier's office	in house	meeting the public, all the different people	unhappy patients worry about doing job properly
RA6 **(50s)**	3 years Ladbrokes Burtons	AMSPAR practice receptionist programme	working with people	downloading prescriptions reading doctors' atrocious writing on test results

Practice B

Receptionist (age)	Length of service Previous work	Training	Favourite aspect of job	Least favourite aspect of job
RB1 (52)	13 years insurance office supermarket checkout	AMSPAR practice receptionist programme aggression management computer use	working on front desk solving problems for patients	registering patients (time-consuming paperwork)
RB2 (44)	12 years office work/ housewife	AMSPAR practice receptionist programme aggression management computer use	enjoys variety of the job	
RB3 (36)	5 years (3 as reception manager) pharmacy dispenser medical receptionist	AMSPAR practice receptionist programme aggression management deaf awareness medical terminology	working with the public	filing
RB4 (58)	19 years office work police 999 switchboard	In-house training aggression management	dealing with patients face to face	computer work
RB5 (55)	3 years bank clerk	AMSPAR practice receptionist programme aggression management deaf awareness medical terminology	dealing with patients and getting good results for them	failing to help someone over the phone
RB6 (40s)	4 years hospital secretary	FE college training in medical reception work aggression management	communicating with patients	

Practice C

Receptionist (age)	Length of service Previous work	Training	Favourite aspect of job	Least favourite aspect of job
RC1 (28)	2 years pharmacy dispenser reception work	in-house medical terminology	repeat prescription processing	constantly answering phone occasional monotony
RC2 (59)	9 years office work	in-house (lacks confidence, would like more training)	all aspects being thanked by patients	situations which she lacks the confidence to deal with
RC3 (58)	15 years housewife (unwilling to mention previous work)	in-house (courses promised but never happen)	computer work	monotony of front desk work
RC4 (58)	1 year medical reception work	no training (would like more training, draws on existing skills)	being part of the reception team	filing

APPENDIX 3

CONVERSATIONAL ROUTINES

A routine here is defined as two or more examples of the same formulation. When a cell is empty no routine has developed. Items in brackets are supplementary to the basic routine and items between forward slashes are alternative versions of the same routine. The Confirmation stage is not included because receptionists mainly enact it by echoing the patient's preceding utterance.

	INFORMATION CHECK			**RESOLUTION**			**QUESTIONNAIRE**
	Name check	**Address check**	**DOB/Doctor check**	**Check-in**	**Prescription collection**	**Appointment making**	**Questionnaire**
RA1	a) what's the name? b) what's your name?			a) that's fine . that's room (*no.*) for you . just take a wee seat (okay?) *b)(name)*'ll call you		that's (+ *appointment details)*	can I give you this/that form (to fill in) (please)
RA2	a) the name is? b) the name please?			it's room four . if you have a seat she'll/ he'll call your name (okay?)			
RA3	what's the name?	and the address?		that's Dr (*name*) room (*no.*) . if you take a seat he'll give you a call when he's ready	there we/you go		a) that's (.) just a wee tick-off . form . for you b) if you could just tick off that for us that be great thanks

RA4	a) what was the name? b) what's the name?			if you just have a seat *name*'ll come and give you a call . okay?	there you go	that's (+ *appointment details)*	apparently I've to give you that/one of these
RA6	what was your name?	and what was the/your address?		if you have a wee seat . it's Dr (*name*) room (*no.*) . (he'll give you a call) (okay?)	that's you	that's (+ *appointment details)*	and I'll gie you one of the:se and if you fill that in and put it in that box
RB1	a) what was your name? b) what's your name?	what's the address (for that)?		that's fine	that's it/your prescription (there)		a) can I just give you this to fill in? b) if you just want to quickly . fill that in
RB2	a) what was your/the name? b) what's the (first) name?		who's it with/to see?	a) okay b) that's fine . (if you just take a seat . thank you/for me)	that's your prescription (there)		a)can I give you that form to . fill in? b) if I can just ask you to fill (.) that out . it'll just take a couple of minutes
RB3	a) what was the name? b) what's the name?			that's fine + name	that's your prescription		can I get you to fill that/another form in for me?
RB4	what was the name (dear)?			that's lovely/fine (dear)	that's lovely/it . okay (dear)?		a) I'll give you that/ this/another one b) can I just give you that as well . just to (.) check/ tick off .

RB6	what was your name (please)?	what's the address for that (one) (please)?		a) that's fine + *first name* (if you just have a seat please)		there you are (*appointment card*)	a) can I give you this/one of these now? b) I'll just do a swap with you . you can have that one now
RC1	and your name please?			lovely . (if you'll) (just) have a seat in the waiting-room please	there you are	lovely . and that's him/you in at (+ *appointment details)*	I'll give you that/this
RC2	and your/the name is?		a) could I ask your date of birth please b) and who's your appointment with?	that's fine . if you'd just like to have a seat thank you	there you are	that's fine . that's (you booked in) (+ *appointment details)*	
RC3	what was your name (please)?	what's your date of birth (please)?			there you are	there you are (*appointment card*)	

APPENDIX 4

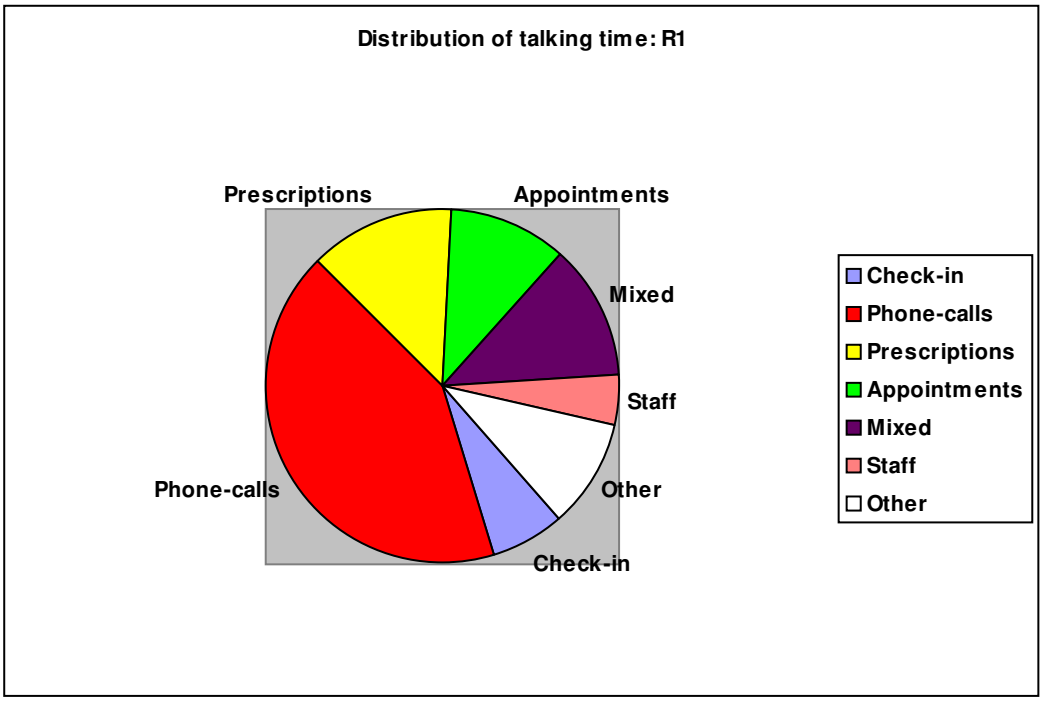
AGENCY IN FRONT DESK ACTIVITIES

Code name	Service offers	Front desk administration	Practice information	Registration	Problem solving	Appointment making	Research
RA1	I	I			I, we (the practice)e	I, we (the practice), we (receptionist & patient), the computer	I, me
RA2					they/ the girls (chemist staff)	she (the doctor)	I
RA3		I				I	us (receptionists)
RA4		I				I, we (the practice)	I
RA5		I	we (the practice)	I			I
RA6	I					I, the computer	I
RB1	I	I, me	we (the practice)				us (receptionists), the lady, the girl
RB2	I	I, me				we (the practice)	us
RB3	I	I, me			I	I, we (the practice)	
RB4		I, me	we (the practice)			I, we (the practice)	me
RB5		I, me					us (receptionists)
RB6	I				I, us		
RC1	I	I		we, us (the practice)	I	he/she (the doctor)	I
RC2	I	I			I, we	I	I
RC3		me		I, we (the practice)		I, he (the doctor)	
RC4				we (the practice)			

Appendix 5

Sample training materials

Personal work profile



Time recorded: 62 minutes 29 seconds

Activity	Interactions
Checking in	12
Issuing prescriptions	3
Prescription repeats	11
Giving appointments	4
Mixed	7
Working with other staff	15
Phone calls	24
TOTAL	76

TASK 1

1a) What do you think you say?

When a patient comes to the front desk at the beginning of a visit to the practice it is normally the receptionist who speaks first. When the patient speaks first it is usually only after eye-contact has been made with the receptionist. Below is a list of possible openings:

eye contact only	yes?
hiya	hi there
hello	hello there
morning (or afternoon)	good morning (or afternoon)
can I help you?	do you have an appointment?

Discuss the following questions with your group/partner:

(i) Which of the above do you personally most often begin with?

(ii) Do you open in a different way with different patients and, if so, how?

1b) What you actually say:

Greetings	**Offers and Elicitors**
hi there (15)	can I help you? (4)
morning (7)	do you have an appointment? (1)
hiya (4)	yes? (12)
hello (2)	**Other**
hi (1)	yes? . hello (2)
hello there (1)	apologies (3)
good morning (1)	patient speaks first (25)

1c) Follow-up

Discuss examples of different openings from the practice data

TASK 2

Fill in the gaps after the letters (a) to (j) with suggestions about what the receptionist said.

R: hi there . thank ↑you (*takes consent form*)

P: (1) right (.) see that number two there

R: *(a)* _____ that should be one <u>three</u> times a day. he's got one <u>five</u> times a day

R: (1) right . that's really the doctor that has to change that . *(b)* _____

P: =aye well . that's || what it is

R: || *(c)* _____

P: aye I'm ordering (th)em (.) aye

R: so what you're saying is this should be one <u>three</u> times a day?

P: (.) aye (.) mhm (1)

R: || I'll *(d)*_____ put a *(e)* _____ note

P: || it was the thing that pullt me up the last time I got it {R: aha} along at (.) the chemist

R: should be *(f)* _____three *(g)* _____ a day

P: right

R: *(h)* _____ that's a wee note on it {P: right} doctor'll see that

P: || okay then . thanks

R: || thank you *(i)*_____ *j)* _____

TASK 2: answers

(Recommended feedback comments for the trainer are shown in superscript)

Example 1

R: hi there . thank ↑you (*takes consent form*)

P: (1) right (.) see that number two there

(a) {**R: aha**} Good to acknowledge that you are listening

that should be one three times a day. he's got one five times a day

R: (1) right . that's really the doctor that has to change that . *(b)* **I cannae do anything about that**= Better to apologise in some way eg 'I'm sorry but I can't do anything about that'

P: =aye well . that's || what it is

R: || *(c)* **are ye ordering these?** Good to check using questions expecting the answer 'yes' or 'no'

P: aye I'm ordering (th)em (.) aye

R: so what you're saying is this should be one three times a day?

P: (.) aye (.) mhm (1)

R: || I'll *(d)* **just** put a *(e)* **wee** note Good to use so-called 'minimisers' to reduce tension. P reacts well.

P: || it was the thing that pullt me up the last time I got it {R: aha} along at (.) the chemist

R: should be *(f)* **one** three *(g)* **times**. a day Good to check accuracy of information by repetition

P: right

R: *(h)* **okay** that's a wee note on it Good to give positive feedback and information to P {P: right} doctor'll see that

P: || okay then . thanks

R: || thank you *(i)* **then** Use of word 'then' indicates finality. Also good to echo P's words. *(j)* **ba-bye** Good to say 'bye' in some way

TASK 3

A man in his early thirties has come to the practice to enquire about his father's prescription, which has been made up wrongly. He seems to be worried both about his mother, who is in hospital, and his father, who is staying with him and requires a number of different medications. Read the transcript aloud with a partner then consider how a different choice of words at the points which are arrowed might have helped to reduce the length of time that the receptionist spent with this patient.
(R = Receptionist (bold font) and P =Patient (regular font)

R: || **yes:**
P: || morning (.) I don't know how to explain this . I've just been tae the chemist (.) and I was picking up my Dad's: (.) repeat prescription {R: aha} and not all the stuff: (.) has been put on it (.) and I'm just wondering (.) why: he (1) they say in case it was coming down in two parts which I find quite
R: **right . what's the name?**
P: it was JK (*man's name*)
R: **(3) and the add<u>re:ss</u>?**
P: 249 N Drive (*phone starts ringing*)
→ **R:** **(29) right . there's th- three i(t)ems went through . sh-. how- how many . how many should i(t)'ve been? (1) do you (?think) there's**
P: e:r . there shoulda been the (.) suspension as well which I was . I put down for <u>two</u> bottles o' that and (.) I don't know if that's on the computer as <u>two</u> . or <u>one</u> (.) and I don't know if I put down for the granules . the granules (*several words unclear*) but it's the suspension that I'm almost run out of (.) (*sniffs*)
R: **(.) right could you leave that until after four this afternoon || and I'll get a doctor to get that**
P: || n::: no really cos (.) I live in Edin- . er through in Livingston and I've got tae travel back and forf (sic) (.) || and my <u>Dad</u>'s staying with <u>me</u>
R: || **unfortunately it's items that I've got to get a <u>doctor</u> to do** {P: o:::h} **and I can't . and I- I need to get** →
them to actually {P: ts:::} **physically do the prescription || and sign it**
P: || do you know (.) <u>why</u> they weren't done then?
R: **I . I have <u>no</u> idea . I'd need to go . what . find out what day you** →
handed it in and go and {P: yeah} **check on the request slip** {P: yeah} **to make sure that they've definitely been requested**
P: ri::ght cos they're all (.) ticked off (1) that's the stuff I really need . it's just more inconvenient cos my Dad's staying wi' me while my Mum's in hospital like . you know
R: **aha . if ye just give me || a se-**
P: || right . okay . no problem

R: (*phone has rung 28 times*) **good morning . reception. can I put ye on hold for one moment please**

R: **(*inbreath*) a::h . do you know . do you know what day it was handed . the request was handed in?**

P: (2) l:ast (1) pw:::: Wednesday or Thursday I think
R: **Wednesday or Thursday**
P: I think (.) kyu

(Receptionist leaves desk and returns with back copies of prescription request slips)

P: maybe sending ye on a wild goose chase there (1) h::a
→ **R: (1) it's just we've got to <u>do</u> this || or**
P: || yeah . no . I understand (5) it's just that my (.) Mum's neighbour's phoned him up to say that the (.) chemist had delivered the stuff but obviously they can't get in cos there's no-one there {R: yeah} so I went this morning and I looked in the bag and it- . it's no all there . (she) looked at me and I'm (.) "what is it?" . she says "ye'll have to go and check with the doctor" . I went "oh" . (*draws in and releases breath*) (7) no it was on one o' the (.) prescription forms like that (*sniffs*)
R: it was on one o these ones || right
P: || aye . I got that the last time . I- I just ticked them off and (1) what I needed (*sniffs*) (2) yeah that's it (*sniffs*)
→ **R: (3) that's probably <u>why</u> (.) for some reason there's two**
P: aye . it's two different things though (3) that's || don't need that
R: || aha . that's the three . that's what mi- . || what I mean
P: || yeah (.) that's . <u>no</u> for <u>that</u> . and times two for tha:t
R: I see (*several garbled words*) they're <u>no</u> . eeh hee
P: they know what times two means like
R: well they know what times two means but (.) I mean you want
→ **something and you tick it and you've crossed that as you don't want and you've crossed that as well || and the girls've actually**
P: || I was needin <u>two</u> (.) that's why I put times two . that's what I use wi' <u>my</u> doctor . you know . didn't think it was too hard that one . I'm es no saying <u>you</u> . I'm just thinking the <u>doctor</u> . I'm no thinking it too hard to (.) understand that one
R: (.) well I- . it's bec<u>ause</u> there's a cross that it's {P: yeah} it . the other three items've {P: yeah} been ticked {P: yeah} and those
→ **two've been crossed and they've taken it that they didn't {P: yes} they didn't want .|| they couldna . looking at that you could actually take it as . well (.) those**
P: || yeah but (.) what's the . what's the <u>two</u> for then?
R: they two items (.) two items crossed off
P: yea:h . I can understand tha(t) as well like|| you know but (*sucks in breath*)
R: || it's. it's easy done {P: mmm}
(.) e:m (.) if ye take a seat I'll see if I can't get a hold of a doctor to do that just now for you=
P: =if ye wouldn't mind it would be <u>very</u> much appreciated
R: er . ye might need to wait for a wee while . that's the only thing . okay?
P: (*moving away*) better than coming back . tha:nk you

TOTAL TIME : 4 minutes 36 seconds

TASK 3: Comments and alternatives.

(Recommended feedback comments for the trainer are shown in superscript)

R: || **hi there** Better to open with greeting (or offer).

P: || morning (.) I don't know how to explain this . I've just been tae the chemist (.) and I was picking up my Dad's: (.) repeat prescription {R: aha} and not all the stuff: (.) has been put on it (.) and I'm just wondering (.) why: he (1) they say in case it was coming down in two parts which I find quite P breathless and upset

R: **okay . could you give me your Dad's name please**

Receptionist takes patient's name and address then asks:

right . how many items should there've been Mr K? **Calm the situation by asking direct question which goes straight to the heart of the matter. Possibly he would then give a more direct answer. Use P's title to show he is being taken seriously.**

P: e:r . there shoulda been the (.) suspension as well which I was . I put down for <u>two</u> bo(tt)les o' that and (.) I don't know if that's on the computer as <u>two</u> . or <u>one</u> (.) and I don't know if I put down for the granules . the granules (several words unclear) but it's the suspension that I'm almost run out of (.) (*sniffs*) P seems to be in a panic and in need of clear guidance

R: (.) **okay . could you leave that until after four this afternoon ||and I'll get a doctor to get that**

P: ||n::: no really cos (.) I live in Edin- . er through in Livingston and I've got tae travel back and forf (sic) (.) || and my <u>Dad</u>'s staying with <u>me</u> P still stressed and determined to get a result. Bracketed interjections from patient while R is talking show this too (see below).

R: || **unfortunately it's items that a <u>doctor</u> has to do** {P: o:::h} **they have to actually** {P: ts:::} **physically do the prescription** || **and sign it** Take personal element out of explanation and make it clear it's a matter only for the doctor.

P: || do you know (.) <u>why</u> they weren't done then?

R: **I'm sorry I don't** Better to apologise when saying no **but I can check on the request slip if you like** Make the offer of help simple and clear.

P: ri::ght cos they're all (.) ticked off (1) that's the stuff I really need . it's just more inconvenient cos my Dad's staying wi' me while my Mum's in hospital like . you know P wants R to know how difficult things are for him.

R: **aha . if ye just give me || a se-**

P: || right . okay . no problem Readiness to accept break suggests P is worried rather than angry.

R: (*phone has rung 28 times*) **good morning . reception. can I put ye on hold for one moment please** Phone was ringing throughout previous exchanges, causing stress. Saying a bit less might have allowed R to answer it sooner.

R: (*inbreath*) **a::h . do you know . do you know what day it was handed . the request was handed in?**

P: (2) l:ast (1) pw:::: Wednesday or Thursday I think

R: **Wednesday or Thursday**

P: I think (.) kyu

Receptionist leaves desk and returns with back copies of prescription request slips

P: maybe sending ye on a wild goose chase there (1) h::a An indirect apology.

R: **(1) no problem** Simply accept the apology. R wants to start speaking about problems again anyway..

P: yeah . no . I understand (5) it's just that my (.) Mum's neighbour's phoned him up to say that the (.) chemist had delivered the stuff but obviously they can't get in cos there's no-one there {R: yeah} so I went this morning and I looked in the bag and it- . it's no all there . (she) looked at me and I'm (.) "what is it?" . she says "ye'll have to go and check with the doctor" . I went "oh" . (*draws in and releases breath*) (7) no it was on one o' the (.) prescription forms like that (*sniffs*)

R: **was it on one of these ones?** More appropriate/polite to ask question rather than make statement

P: aye . I got that the last time . I- I just ticked them off and (1) what I needed (*sniffs*) (2) yeah that's it (*sniffs*)

R: **(3) that's probably <u>why</u> (.) for some reason there's two** Necessary information check.

P: aye . it's two different things though (3) that's || don't need that

R: || **aha** Just let P talk with basic acknowledgement of attention. take stress out of situation.

P: yeah (.) that's . <u>no</u> for <u>that</u> . and times two for tha:t

R: **I see** And again

P: they know what times two means like

R: **aha .** And again. i.e. avoid argument

P: I was needin <u>two</u> (.) that's why I put times two . that's what I use wi' <u>my</u> doctor . you know . didn't think it was too hard that one . I'm es no saying <u>you</u> . I'm just thinking the <u>doctor</u> . I'm no thinking it too hard to (.) understand that one

R: sure but **Agree before disagreeing** to avoid any confusion next time you'd probably be better putting a tick for all the items you need . that way the girls in the chemist's will know what to do **Make all the same points without criticising what P has done.**

P: yea:h . I can understand that as well like|| you know but (*sucks in breath*)

R: || **it's. it's easy done** Good strategy. Shows understanding and sympathy. P reacts with 'mmm' where before he kept saying 'yeah' because he wanted to get in another word {P: mmm} **(.) e:m (.) if ye take a seat I'll see if I can't get a hold of a doctor to do that just now for you=**

P: =if ye wouldn't mind it would be <u>very</u> much appreciated P seems genuinely pleased and relieved that worrying problem has been sorted out

R: **er . ye might need to wait for a wee while . that's the only thing . okay?**

P: (*moving away*) better than coming back . tha:nk you

TASK 4

(Showing examples of backstage talk and asking receptionists to identify the features which are unlikely to be used in encounters with patients.)

1	R1:	(*answering question which can't be heard*) think
2		so . yeah . it would appear to be (1) mhm . a lot
3		of them are . blocked off . aren't they
4	R2:	(1) who? oh god || aye
5	R1:	|| surgeries on Tuesday
6	R2:	(1) yeah . right enough . is it one of them or two?
7		Mark's (*first name of GP*) as well is it?
8	R1:	mhm (.) two I think
9	R2:	(*long yawn*) och . excuse me
10	R3:	so what did you think yesterday? (*R2 went on computer course*)
11	R1:	it was good
12	R3:	(.) did you enjoy it?
13	R1:	mhm (2) but I got a row

(R: receptionist)

Features which are unlikely to be used in encounters with patients

1. The topics: work-related reference to the appointment schedule and the personal query about the computer course
2. The indefiniteness and vagueness
3. The tag question (aren't they?)
4. The expletive "oh god".
5. The yawning

TASK 5

(*The comments appraised as potentially negative are shown in bold type*)

Absence of apology

P: (1) right (.) see that number two there {R: aha} that should be one three times a day . he's got one five times a day

R: (1) right . that's really the doctor that has to change that . **I cannae do anything about that=**

Over-directness

F/41-60/lm/om

RA6: yes . hello

PA66: I've just to (.) re- . remind him he's to phone me

RA6: **remind . who am I meant to be reminding?** . Dr?

PA66: MacLaverty . yes sorry (.) I'm just expecting you to know! . er that . on Monday . he's gonna phone me about eleven o'clock

Language problems

The receptionist is checking the name of a Chinese patient.

R4: eh . now did you say Kwok?

P46: yeah yeah . Chi Wah Kwok

R4: (5) what was you:r (.) **Christian name**?

P46: Kw- . Kwok

R4: (3) **your Christian name**

P46: Kwok . K-W-O-K

R4: **that's your surname . I want your Christian name**

P46: a:w . Chi Wah || Chi Wah

R4: || Sa- Sa- (6) Chi (*vowel sound mistakenly pronounced /**ai**/ instead of /**I:**/***) Wah?

P46: Chi (*pronounced Chee*) Wah . yes

R4: mhm . mhm

TASK 6

Hesitancy

eh . appointment wi' . Dr Hubble

e:h . Dr Peake

e:h W S's prescription please

e:h . I've to hand that in

e:h . prescription for S

em . that is a letter from the hospital

er Dr Moyles for half past

nurse: **eh** . nine forty-five

hi . **em** . P . S for Dr Dune

morning **er** . prescription for M R|| please

I've got one at **er** . twenty to ten wi' Dr Anderson

got an appointment at **eh** . twenty . ten to eleven

(.) got an appointment . **er** . J's got an appointment . for Dr Dune

Doubt and uncertainty

got an appointment for . **who's it <u>with</u>**? ten past ten with **e:r** . **was that** . Hubble?

my son's **got a . got** an appointment to see Dr Moyles

I'm a bit late . I want Dr Ireland . **I think** it was twenty past te:n

I've got one at . **I believe** at <u>five</u> past and one at <u>twenty</u> past

I wonder if I could **eh** . do a repeat prescription please

Lack of competence

(*The receptionist has asked the patient to give the name of a prescription item*)

pet . I can't remember (2) I'm no a good reader . I just taen them you know (.) I was looking for the box this morning (1) I noticed it was missing but I'm no a very good reader . so it- I couldnae remember the name of them (*sniffs, sighs*)

TASK 7

Look at the forms of wording which receptionists use to tell patients that there are no appointments available. What differences are there between them? Are these differences of any importance?

Example1
F/26-40

R: hiya

P: em . I'm here for open surgery

R: right . the open surgery's full . is it something that's an emergency?

Example 2
F/26-40

R: morning

P: hi . can I put my name down for open surgery

R: right . I'm afraid the open surgery's actually closed just now . it's finished (.) is there . is it a medical emergency

Example 3
F/61-75

P: e:h . I want to put an appointment in for Dr Brown

R: Dr Brown? . right . he's still away . he's not here next week either I'm afraid

P: what about the week after?

R: he- . no

P: oh my godness (sic)

R: I know . what a lot of time off they get eh?

TASK 8

Look at the two examples below. What do you think about the receptionists' comments in the boxes?

M/61-75

R4: thanks . that's lovely . thanks . would you like a card Mr T? (.) || yes?

P54: || possibly . in case my age kicks in (*laughs*)

R4: I've got that too

P54: (*laughs*)

R4: I'm like that

P54: (*laughs*)

P20: F/16-25, P24: F/26-40

P20: hello hen . how are you? . what a size he's getting eh?

R5: is that it Susan?

P24: that's everything thanks

R5: right . if you need this one

P24: (*continues to speak to P20*)

R5: Susan . finish with me first please would you?

P24: sorry

R5: okay . before you have your chats . ehm . that one . if you want it after you've seen the doctor let me know

EXAMPLES OF DIFFERENT RELATIONAL STYLES

Routine politeness

M/26-40

1	R8:	can I help you there? . what's the name?	←		
2	P68:	Michael F			
3	R8:	okay (10) what's your address?		←	
4	P68:	er . it's 14 G Place			
5	R8:	there you go			
6	P68:	have you got a form for changing address please?			
7	R8:	oh right (16) what's your date of birth?		←	
8	P68:	it's sixteen six nineteen seventy-eight			
9	R8:	is that your old address there?			←
10	P68:	aye			
11	R8:	yeah? (5) thank you . what's your new address?	←		
12	P68:	it's 50/4 P Road			
13		(unclear exchange)			
14	R8:	right . cheers then . bye			

Humour and teasing

M/41-60

R5: morning

P31: I forgot my appointment yesterday . I'll have to make another one

R5: oh . you're naughty aren't you?

P31: I know . I've got . I've wrote that in there as well . whenever I remember . ha ha ha

R5: what we going to do with you? . well what we'll do is we'll put it on your forehead and when you look in the mirror you'll see it

Personal talk

F/26-40

P55: hi
(several turns unclear)
R6: is that you already . is that no awfae quick?
P55: it didn't seem awfae quick to me
R6: let's see her then (.) look at her eh . oh . she's gorgeous eh? . beautiful
P55: (unclear)
R6: oh . she's really beautiful . what's her name?
P55: Adelise
R6: Annalise?
P55: Adelise
R6: how did you decide on that?
P55: in the baby book
R6: was it?
P55: aye . I couldn't settle on a name so I decided to have a look in there {R6: aye} and that caught my eye
R6: that's the one that caught your eye (.) she looks like that name though eh?
P55: aye . she does actually . I'm getting used to it though eh?
R6: aye (.) how do you spell it?
P55: (*spells name*)
R6: that's it?
P55: aye
R6: was she . was she big when she was born or what?
P55: she was six eleven but she was ehm . but she was only forty-five centimetres
R6: was she?
P55: she was really petite eh?
R6: aye

Appendix 6

Research documents

1. PROTOCOL SUBMITTED TO RESEARCH ETHICS COMMITTEE

Communication between medical receptionists and members of the public in GP surgeries.

Introduction

It is clear from recent policy statements (e.g. Scottish Executive, 2000) that improved patient access and better communication with the public will be central objectives in the future development of the National Health Service in Scotland. Approximately ninety per cent of all medical consultations take place in primary care settings, where medical receptionists are the first point of contact for the majority of users. Receptionists play a demonstrably important role in health care teams (Hughes, 1989) but recent research into primary care services in Scotland has shown that, although they often facilitate public access, receptionists may also on occasion impede it (Scottish Consumer Council, 2001). Such inconsistencies in performance can be successfully explored using qualitative research techniques (Mays and Pope, 2000), which allow the nature of interaction to be examined in greater depth. Language is the primary vehicle through which receptionists carry out their work and better understanding of the typical linguistic structures used in reception desk dialogues will make it easier to identify reasons for communicative successes and failures. A study is therefore proposed of the language used in interaction between medical receptionists and members of the public in three, contrasted, general practice settings.

Background

Although receptionists in general practice have a central role in health care delivery they have been the subject of relatively little research. It has, however, been shown that, while receptionists themselves regard helping patients as their main concern (Copeman and van Zwanenberg, 1988; Eisner and Britten, 1998), there is some public dissatisfaction with their interpretation and performance of the gatekeeper role (Arber and Sawyer, 1985; Hallam, 1993.). It has also been demonstrated that some groups, for example teenagers (Jacobson et al., 2001), experience greater access problems than others, particularly in relation to receptionists, though it is not absolutely clear why this is so.

Linguistic analysis has become an invaluable aid to the understanding of communication in health care settings. There are numerous studies of doctor-patient interaction while, more recently, interest has been developing in the wider context of verbal communication in health service contexts. Cicourel, for example, (1999) has analysed the language of receptionists in a paediatric clinic while Roberts and Sarangi (1999; 2000) have collaborated with the Royal College of General Practitioners to examine gatekeeping discourse in admissions interviews. The latter study produced recommendations for improvements to current practice. Despite this growing interest in the mechanics of health care communication, there has as yet been no linguistic research into verbal interaction involving receptionists in general practice.

Objectives

The four main research questions will be as follows:

1. How can improved understanding of verbal interaction between receptionists

and members of the public contribute to receptionist training?

2. In what ways do the linguistic choices made by participants impede or obstruct successful communication?

3. What are the normative speech routines used in both face-to-face and telephone interaction between receptionists and members of the public in general practice surgeries?

4. What do individual variations in the enactment of these routines reveal about participants and their understanding of the interaction?

Research plan

The research will be carried out in three practices and the following procedures adopted at each of them.

- A mini-profile will be developed of practice administration, focusing on the work of receptionists and their training.
- Informal interviews will be conducted with participating receptionists and, where applicable, the practice manager.
- A research diary will be kept.
- Numbers will be monitored of those patients who decide to take part in the study and those who decline.
- Subjects will be asked to complete a short, anonymous, questionnaire which will provide information about their age, sex and patterns of attendance at the practice.
- Audio-recordings will be made of receptionist-public interaction, both face-to-face and by telephone. They will be made from a position in which the researcher is unable to hear the interaction between receptionists and patients directly, and is thus unable to hear exchanges involving patients who have not given consent
- Linguistic transcriptions will be made of the recordings.
- The recordings and transcriptions will be analysed for both task-related and interpersonal linguistic patterns.

Outcomes

This is a qualitative research project which will be used to achieve deeper understanding through an analyis which is grounded in the data and backed up by ethnographic information. Although statistics will not be applied, it is expected that there will be a degree of generalisability in the study. This will be based on the documentation of standard, task-related, speech patterns and identification of both normal routines and deviations from them.

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2. INFORMATION SHEET

(Header)
(Practice logo)

RECEPTIONIST RESEARCH STUDY

Over the last few days Mrs Heather Hewitt, a linguist, has been working at the Health Centre, studying conversations between receptionists and visitors to the practice. It is hoped that the results of the study can be used to improve the service received both at this practice and elsewhere in the NHS. They may also be published in medical or linguistic journals.

We would like to make the audio recording of your telephone call to the practice on February 3rd 2003 available to Mrs Hewitt for analysis. If you are happy for us to do this, we would be grateful if you could sign the attached Consent Form and return it to us in the stamped addressed envelope provided, together with the short questionnaire. We can assure you that the study will be completely CONFIDENTIAL and ANONYMOUS:

- Your name will not be used.
- The practice will not be identified.
- Only Mrs Hewitt will see the notes and hear the recordings, which will be destroyed when the study is complete.

If you decide that you do not wish to take part in the study after all, or if you have any other questions about it, you can contact either Mrs Hewitt or the independent adviser, Mrs Pat Matthews, at any time over the next six months.

Mrs Heather Hewitt,
Department of Theoretical and Applied Linguistics,
University of Edinburgh,
40, George Square,
Edinburgh,
EH8 9LL.
Email: heatherh@ling.ed.ac.uk
Tel: 0131 447 0268

Mrs Pat Matthews,
Non-Executive Trustee,
Lothian Primary Care NHS Trust,
The Astley Ainslie Hospital,
133 Grange Loan,
Edinburgh,
EH9 2HL.
Tel: 01875 830 203

This study has been approved by the Lothian Research Ethics Committee.

Please note that your treatment will not be affected if you do not wish to take part in the study.

3. CONSENT FORM

RECEPTIONIST RESEARCH STUDY

Ethics committee reference number: LREC/2002/7/27

CONSENT FORM

I have read and fully understood the information sheet and am willing to take part in the Receptionist Study.

Name: ……..

Signature:…….

Date:…….

4. SAMPLE QUESTIONNAIRE

RECEPTIONIST RESEARCH STUDY QUESTIONNAIRE

To assist with the study it would be helpful if you could answer the following 4 questions. Please tick as appropriate.

1. ***Are you male or female?***

   male ……
   female ……

2. ***Which age group do you belong to?***

   16-25 ……
   26-40 ……
   41-60 ……
   61-75 ……
   75+ ……

3. ***When did you last visit this practice?***

   yesterday ……
   in the last week ……
   in the last month ……
   in the last year …….
   other …….

4. ***How often, on average, do you visit the practice?***

   once a week ……
   once a month ……
   every six months ……
   every year ……
   other ……

Please place the completed questionnaire in one of the boxes marked "Receptionist Study".

THANK YOU VERY MUCH FOR YOUR HELP.

5. INFORMATION FOR RECEPTIONISTS & PRACTICE MANAGERS

Communication between receptionists and members of the public in GP surgeries: outline of project.

Reasons for research:

- Receptionists do an important job yet health service researchers have taken little interest in their work.
- Language is the main tool of the receptionist's trade. It would be both useful and interesting to know exactly how receptionists use the speech routines which allow them to carry out their work.
- Expert analysis of what receptionists actually say might make it possible to introduce new elements into training programmes, particularly in order to help them to deal with difficult situations.

Method:

1. Seek the consent of receptionists.

2. Spend a few days in the practice observing and finding out how things work.

3. Talk to each receptionist informally about her job (for about 15 minutes).

4. Make recordings of all receptionist-patient interaction, both face-to-face and by telephone, in the course of one session/one day. (This depends how many patients consent to be recorded. I'd like to get to a total of about 40.)

5. Transcribe and analyse conversations.

6. Provide feedback for practice, possibly in the form of a training session (I'm a qualified language teacher and teacher-trainer)

Imposition on practice:

Apart from the fact that I'd be on the premises for a few days, this relates mainly to the provisions for getting the informed consent of subjects.

1. Notices about the research would be put up at the practice door and in the reception area.

2. On the day of recording, a colleague would sit at the door handing out information sheets and consent forms (both attached). Those willing to be recorded would be asked to hand in the signed consent form to the

receptionist, who would then give the person a short questionnaire (also attached) to fill in. I would activate the audio recorder only if a consent form was handed in.

3. For the telephone, a recorded message would be put on the system, indicating that the conversation might be recorded for training purposes. A letter would then be sent to all those who were recorded asking them to return the signed consent form if they were willing to take part in the research.

I would organise all of this but wouldn't have access to patient details and would therefore have to ask for help when sending out letters to the telephone subjects.

The Lothian Primary Care Research Network will reimburse practices for any encroachment on staff time and will also pay for the translation of the Information Sheet, Consent Form and Questionnaire into the most commonly spoken minority languages.

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6. FEEDBACK FORM FOR RECEPTIONIST TRAINING SESSIONS

FEEDBACK

Thank you very much again for taking part in this study. I hope you have found this feedback session helpful and would be grateful if you could find time to answer the following three questions to let me know your views.

1. Do you think this feedback session has been useful?

2. If yes, which parts have been useful and which parts would you omit?

3. How could the feedback session be improved?

THANKS AGAIN!

Heather

RECEPTIONIST STUDY

Summary of research: Practice B

Method

The study was conducted as follows:

- The lead researcher spent two days at the practice familiarising herself with administrative procedures and carrying out semi-structured interviews with members of the reception team.

- Four hours of audio-recording were made of interaction between receptionists and patients at the front desk. Patients were recruited to the study by two research assistants, who were positioned just inside the main entrance of the practice. They provided information to patients, who were then asked if they would consent to take part. Only consenting patients were recorded. Consenting patients completed questionnaires which asked for information about their age, sex and practice attendance patterns.

- The audio-recordings were transcribed and categorised according to the activities being carried out in them. They were then analysed for selected linguistic characteristics.

- A feedback session, at which the findings of the study will be reviewed, will be provided for all practice staff. Individual receptionists will be given transcripts of their interaction with patients and a commentary on the specific communicative strategies which they use.

Participants

- 6 receptionists and 111 patients (65 female and 46 male) were recorded. The consent rate of receptionists was 100% and that of patients between 65% and 70%.[53]

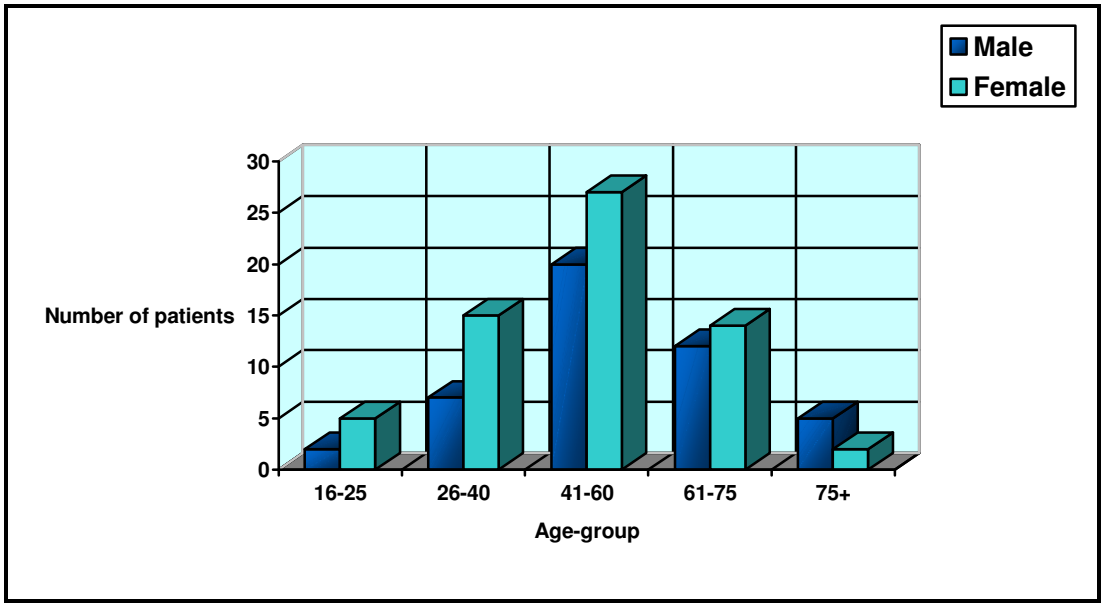
- Analysis of the semi-structured interviews shows that receptionists agree on the following points:

    - ❖ they work well as a team;
    - ❖ they receive good support from clinical staff and never have to make difficult decisions alone;
    - ❖ training courses are extremely helpful;
    - ❖ dealing directly with patients is their favourite part of the job;
    - ❖ they enjoy the variety of the job;
    - ❖ the most difficult aspect of the job is dealing with problematic patients.

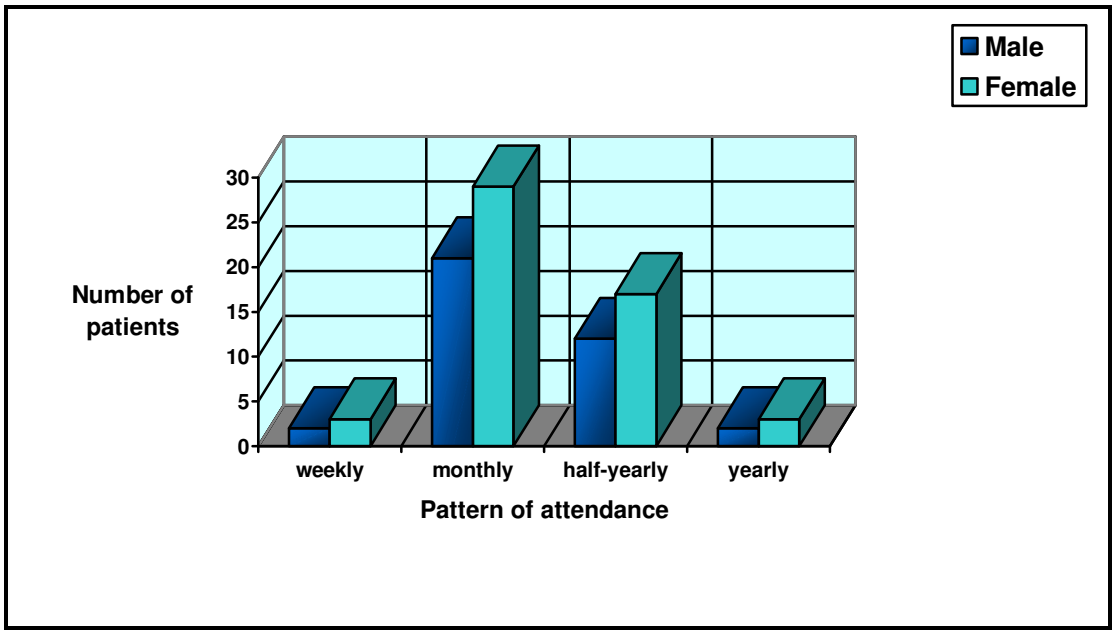
- Almost all consenting patients (109) completed questionnaires, which yielded the information about age, sex and attendance patterns which is displayed in the graphs below:

[53] It is impossible to give a precise figure because there is no exact tally of the number of patients who visited the practice during the period when recordings were being made. In addition, there were some patients who did not have the opportunity to take part because the research assistants were engaged in explaining the study to others at the time when they arrived.

Graph 1: participants by age and sex



Graph 2: participants by attendance pattern



Key findings

1. Forms of interaction

The interaction in the audio-recordings consists of the following activities:

Table 1: activities at front desk

Activity	N
Checking in for appointments	60
Picking up prescription repeats	33
Making appointments	11
Problem solving	10
Incoming phone calls	9
Handing in prescription repeats	4
Handing in letter	1
Picking up letter	1
Registration	1

2. Routine activities

Most interaction at the front desk is fairly predictable, consisting of simple speech routines with standard formats which are familiar to both receptionists and patients. There are nevertheless variations in the language used in these routines. An idea of such variations is given in the table below which shows how receptionists open their interaction with patients.

Table 2: opening the interaction

Receptionist openings	N
Patient-focused openings	
Greeting (1 double)	38
Greeting + offer of service	12
Greeting + consent issue	4
Yes + endearment	7
Yes + endearment +offer of service	2
Consent issue + endearment	1
Total	64
Task-focused openings	
Consent issue	4
Offer of service	27
Total	31
Non-verbal openings	18
TOTAL OPENINGS	113

The table illustrates the following points:

i. Receptionists have a number of different ways of offering service to patients.

ii. Verbal offers, which are in the majority in the data, can be seen as focused either on establishing initial rapport with the patient, in which case they generally consist of some form of greeting, or on the task in hand, in which case a clear offer of service is made.

iii. Forms of opening such as greetings are treated as offers of service by patients. The majority of patients use their first turn at talk to state the reason for attendance at the practice.

iv. In some cases the offer of service is non-verbal.

(Note that in a small number of cases issues pertaining to the patient's granting of consent for the research study take precedence over normal business.)

3. Personal styles

All receptionists involved in the study maintain high levels of courtesy using a mixture of formal and informal styles of linguistic politeness. This is illustrated by the greetings and forms of address which occur in the data. Informal usage includes the greetings 'hi', 'hiya', 'hi there' and 'hello' and forms of address such as 'dear' or the first name of the patient. Formal choices include the greeting 'morning' and the use of the patient's title. Full details of receptionist greeting choices are given in the table below.

Table 3: greeting use

Receptionist	Openings	Greeting	N
Receptionist B1 (22% use)	27	hiya - 4 hi - 2	6
Receptionist B2 (79% use)	24	morning - 8 hi - 11	19
Receptionist B3 (41% use)	17	hi there- 3 hi - 1 hello - 2 hello there - 1	7
Receptionist B4 (6% use)	17	hello - 1	1
Receptionist B5 (100% use)	3	hiya- 2 hi - 1	3
Receptionist B6 (81% use)(	21	hi there - 14 hi - 3	17
Total openings	**113**	**Total greetings**	**53 (47%)**

Patients use linguistic politeness strategies far less than receptionists. For example, less than half of the consenting patients returned receptionist greetings (12 male and 13 female) or used forms of address such as terms of endearment (5 male and 3 female).

4. Problem solving

There are ten examples in the data of encounters in which receptionists solve problems for patients. These include difficulties with appointments, prescriptions, registration, relaying of messages and housing issues. The approach taken by the receptionist depends both on the nature of the problem and the perceived state of mind of the patient. However, a few general observations can be made:

i. Problems are resolved more rapidly when patients are able to explain them fully, assisted if necessary by receptionists.
ii. Patients respond favourably when receptionists provide verbal feedback (e.g. 'aha', 'I see') which indicates that they are paying attention.

iii. Frequent repetition by receptionists of what patients have said is necessary to ensure that problems have been understood correctly.

iv. Tense situations are defused by positive intonation, such as warm voice quality, and personalisation of the receptionist's response, such as the use of the patient's name.

v. Patients require simplified explanations and instruction.

Comments

Receptionists at Practice B are very well trained. Through their talk they maintain high levels of both courtesy and efficiency.

Receptionists communicate effectively with each other and with other members of the practice team. The front desk runs smoothly and patients are dealt with rapidly.

The absence of the telephone from the front desk is an advantage because there is no disruption of communication with patients who are attending the practice.

Patients respond favourably to personalisation of their interaction with receptionists.

Heather Hewitt
4th February 2004